THE JOURNAL OF MEDICAL PRACTICE MANAGEMENT

September/October 2020 | Volume 36 | Number 2

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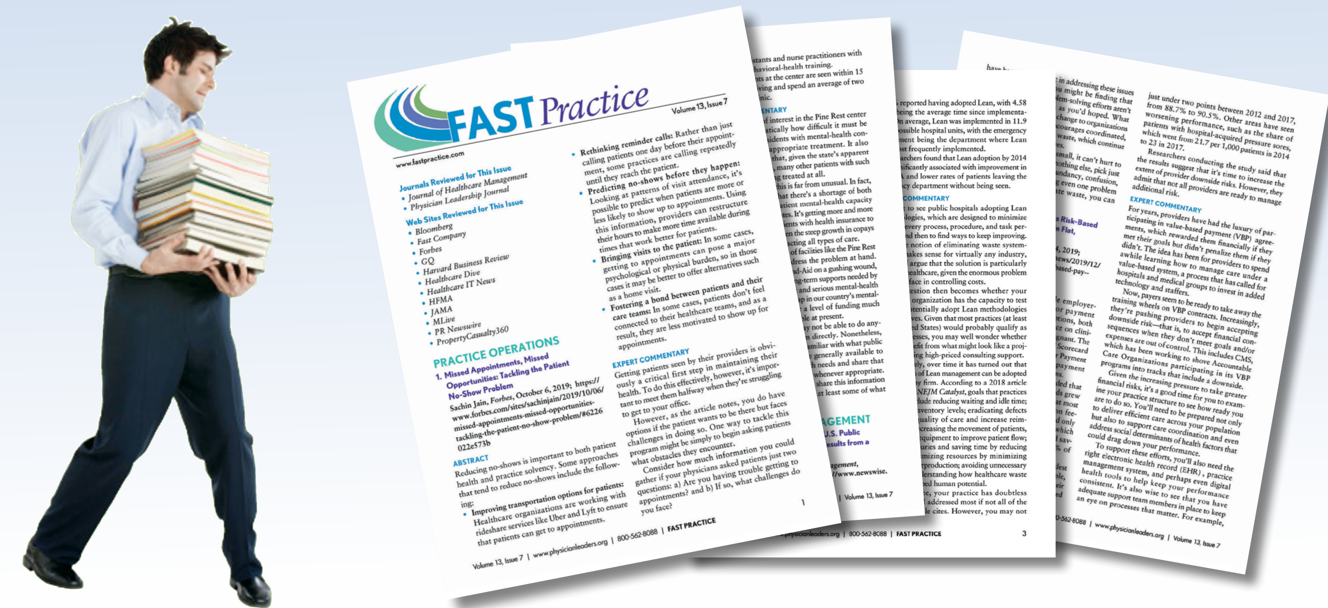

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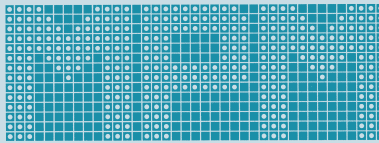

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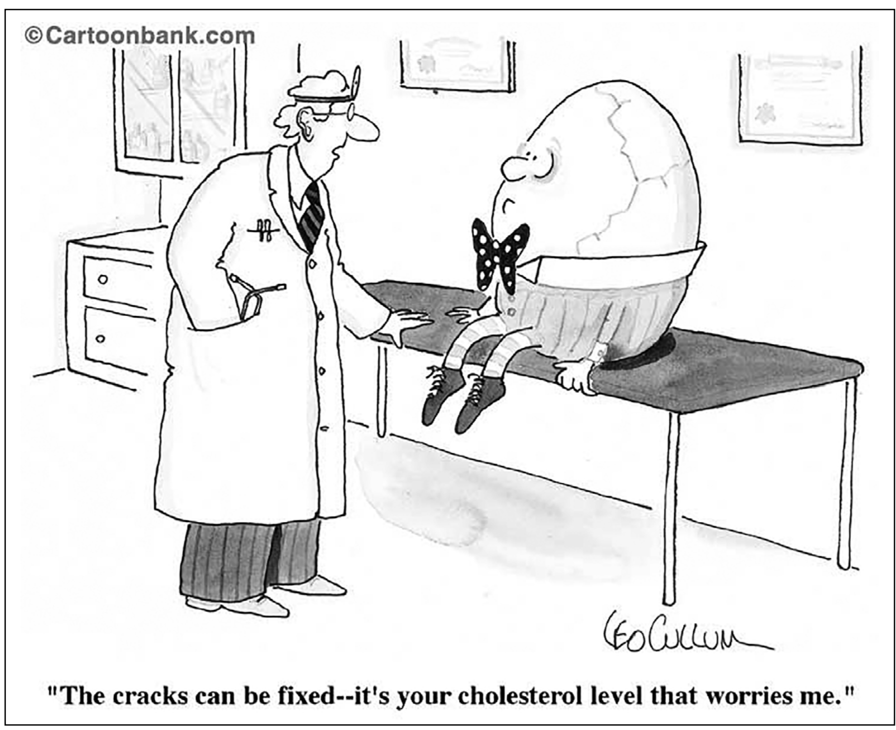

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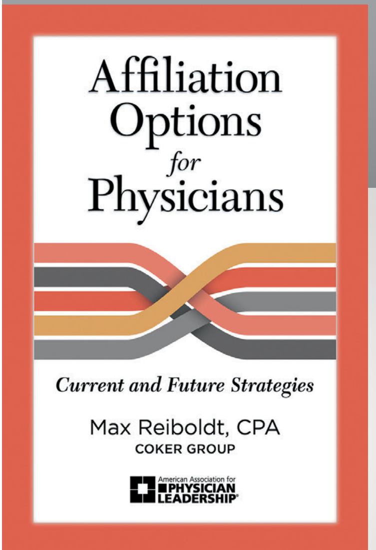
Affiliation Options for Physicians

Current and Future Strategies

By Max Reiboldt, CPA, Coker Group



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A Guide for Making an Informed Choice on Which Affiliation Alternative Is Best for You

The number of available affiliation options can be nearly as daunting and confusing as the uncertainty surrounding which model is the best fit for any organization. Choosing the correct model is best achieved through foundational knowledge – and with an eye on what you can expect the future of healthcare to bring.

In this new book, Max Reiboldt, CPA, equips physicians, physician leaders, health system administrators and private investors with an abundance of knowledge and effective strategies for making sound decisions based on the current and future environment of healthcare practice and delivery.

Max Reiboldt and the editorial team from Coker Group presents those myriad possibilities in an organized and easy-to-digest format that explores the "what" and "how-to" applications of each option, and by providing an historical review of various physician affiliation transactions over the past 20 years, including:

- Physician to physician
- Private group to private group
- Private group to hospital-health systems
- Private group to private equity/outside investors, and more

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Medical Practice Management

From the Editors of *The Journal of Medical Practice Management*® September/October 2020

HEALTH IT

Healthcare Data Breaches to Cost $4 Billion by Year-End, 2020 Will Be Worse

According to a survey conducted by Black Book Market Research, some 96% of healthcare IT professionals agreed that data attackers are outpacing IT's efforts to protect their organizations against hackers. Some 93% of healthcare organizations have experienced data attacks in the past three years, with 57% reporting *five or more* attacks.

The same survey revealed that about 90% of healthcare enterprises have not increased their IT security budgets in the past three years, making them more vulnerable than ever as they rely on older systems and technologies to protect them from the state-of-the-art tools and techniques used by cybercriminals.

CEOs and CFOs struggle with finding an appropriate budget for cybersecurity. Typically, they rely on historical data to guide them in projecting budgets. But cybersecurity is a new and rapidly developing arena; no one seems to know how much they should spend to reach a prudent level of safety.

Medical practices—especially physician-owned groups—have a long history of resisting preventive measures that cost a lot of money. Clearly, effective cybersecurity is expensive, but the costs pale by comparison with costs associated with a data breach. From reparations to communications, from fines and penalties to lost productivity, it all adds up to numbers with a lot of zeros and commas.

You need to take a hard look at your security measures to see if they are providing your practice with a reasonable level of protection against the inevitable attacks (both from outside and from within your organization). And while you're at it, how long has it been since you reviewed your insurance coverage? Chances are good that you need bigger policy limits (not to mention the need to upgrade your policies to include the latest threats).

No one likes to pay astronomic medical liability premiums, but you would be foolish to neglect it in today's litigious environment. Malpractice and cyberattacks are similar in this: it's no longer a matter of *if* but *when* you will be faced with a potentially very expensive problem.

Source: *Medical Liability Monitor*, December 2019

MEDICARE/ MEDICAID

Seventy-Two Percent of All Rural Hospital Closures Are in States That Rejected the Medicaid Expansion

According to recent research, roughly 20% of Americans live in rural areas. These areas have been steadily losing access to hospitals for years, as rural facilities have collapsed financially over time. Of the 106 rural hospitals that have closed since 2010, 77 of them were in states where local legislatures declined to participate in the Medicaid expansion made possible by the Affordable Care Act.

The number of rural hospitals in the United States has been decreasing for some time, with more than 200 closings between 1990 and 2000 according to the U.S. Department of Health and Human Services, with those that have stayed open struggling to stay fully staffed. These closures aren't only due to state refusals of Medicaid expansion funding. Another factor impacting these hospitals is the advancement in medical treatment and technology. Experts note that with scientific development in areas such as neurosurgery, care has migrated to areas of larger populations that can support technology specialists. Still, if state legislatures and governors had accepted Medicaid expansion funds, billions-more dollars would be available to help fund the long-term existence of rural facilities.

Whether or not the Medicaid expansion is the right tool for keeping the doors open at rural hospitals, it seems likely that some sort of rescue will be needed soon. At present, it could almost be said that rural hospitals are in a death spiral, in part because as people leave the area (including due to poor access to healthcare) the facilities have steadily less income. Not only that, but as hospitals close, physicians have less reason to stay in a rural area, much less relocate there, and the struggling hospitals that remain may not be able to afford physicians'' salaries. This will continue to contribute to the growing physician shortage that rural areas are experiencing.

In fact, it seems likely that within the next decade or two, the lack of access to hospitals will become so critical that some form of coordinated federal action will become necessary. This will probably involve immense investments in services and infrastructure that will only serve to shore up an infrastructure already on its last legs.

Instead of waiting until rural healthcare systems collapse utterly, it makes far more sense to look at the situation realistically and develop solutions that are palatable to states where the problem is most acute. The longer we let rural hospitals flounder financially, the harder it will be to set things right.

Source: Luke Darby, GQ, July 30, 2019; https:// www.gq.com/story/rural-hospitals-closing-in-red-states

PHYSICIAN ISSUES

New Book: *50 Nonclinical Careers for Physicians: Fulfilling, Meaningful, and Lucrative Alternatives to Direct Patient Care*, by Sylvie Stacy, MD, MPH

In her book *50 Nonclinical Careers for Physicians: Fulfilling, Meaningful, and Lucrative Alternatives to Direct Patient Care*, preventive medicine physician Sylvie Stacy offers physicians an escape from that bleak "trap" by identifying numerous nonclinical career options that could align with their skillsets and individual financial situation.

While providing an escape from the stressors of clinical medicine, the book also allays much of the potential guilt associated with "selling out" their chosen profession or abandoning patients by explaining how each physician's training and talents directly translate to patient care *outside* of clinical medicine.

The value of *50 Nonclinical Careers for Physicians* is in its actionable advice, including how to market yourself in job applications and interviews, and the abundance of detail it provides—including responsibilities, range of compensation, and stress levels—to help readers decide which alternative career is the best fit for them. And while other authors encourage physicians to start their own business, Stacy focuses on full-time positions that don't require readers to begin their own consulting business or find their own clients.

Here is an excerpt from the Foreword by Peter Angood, MD, CEO and President, American Association for Physician Leadership: "The layout of the book and its chapter design provide focus on the constellation of readily attainable, full-time positions for all types of physicians. It is a must read for those trying to answer their personal question of whether to seek an alternative career path beyond bedside care."

Source: https://shop.physicianleaders.org/collections/all/products/50-nonclinical-careers-for-physicians-fulfilling-meaningful-and-lucrative-alternatives-to-direct-patient-care

PRACTICE OPERATIONS

Policy, Procedure, or Guideline?

When a hospital undertakes to revise any of its processes, administrators and managers understand that they need to document those changes with written policies, procedures, and guidelines. Although the terms are used almost interchangeably in conversation, they really aren't the same:

- **Policies:** Broad expressions of the intent or desired outcome of a process, often multidisciplinary in nature, policies are not designed for idealism or wishful thinking. They are about consistently pursuing the goal. A recommended rule of thumb: "If you can't do it 100% of the time for 100% of applicable [situations], it absolutely should not be a policy."
- **Procedures:** Similar to policies, procedures outline steps required *without exception* to complete the process. Exceptions to stated procedures bring a process to a halt.
- **Guidelines:** These are steps *normally* taken to complete the process at hand. Reasonable departures from guidelines—if the given situation makes it justifiable—would not be considered a violation of the associated policy.

Understanding and maintaining this terminology can go a long way toward simplifying requirements in your organization. Otherwise you run the risk of making the operational rules more complex than the regulations with which you struggle to comply.

Most medical managers recognize the need for updated, standardized, and *written* policies, procedures, and guidelines, but very few can find the time for creating and maintaining up-to-date manuals for the practice. The weaknesses in operational documents show up at the worst times—like when the U.S. Department of Labor is investigating a discrimination claim from a disgruntled former employee, or when the Office for Civil Rights asks you for your HIPAA Violation Sanction Policies.

Ensuring compliance with regulations promulgated by the various agencies attempting to control our industry can be a pretty good motivator, but good policy and procedure manuals bring other, farther-reaching benefits:

- Delineating expectations about everyone's role in each process around the practice;
- Fostering a sense of teamwork as staff members play "by the rules";
- Creating a basis for analyzing and improving critical processes;
- Promoting consistency and predictability for patients as they navigate your office and services; and
- Assisting in budgeting and expense control.

In fact, this list can go on and on. The benefits far outweigh the hassles associated with "doing the paperwork." And it doesn't have to be that hard these days. You can find great boilerplate documentation (including complete manuals)

for just about every aspect of your practice. All you need to do is tailor the provisions and wording to your situation. Many resources are free to the skillful Googler, and publishers sell reasonably priced manuals for you to adapt and adopt.

Source: Greeley Blog, August 20, 2018; https://greeley.com/blog/policy-procedure-or-guideline/

Don't Make These 11 Annoying Email Mistakes That Can Drive Your Coworkers (and Bosses) Crazy

When email began to take over our world in the mid-1990s, we started hearing a new term, "netiquette," referring to good manners online. The rules have continued to develop beyond polite expectations, and now we can describe "best practices" for effectively communicating in the virtual world.

Not everyone knows about the principles outlined here. There are still users who don't understand how offensive and unacceptable it is to type a message in ALL CAPITAL LETTERS. It's the virtual equivalent of shouting in someone's face.

Don't take for granted that your staffers know how to optimize email communication (not to mention text and telephone communication). If you hope to raise the bar of professionalism in your medical practice, it's important to provide specific training. Don't make these mistakes:

1. **Sending from the wrong email address:** Accidentally sending a business email from your personal account can confuse and complicate matters. When the business associate replies, you may not notice it, or your personal spam filter may divert an important response from a business contact.
2. **Using "BCC" carelessly or for deceptive reasons:** When it comes to the blind-copy function, never use it to deceive an addressee who will be under the impression that only the visible addressees are privy to the content.
3. **Writing a generic subject line:** A subject line shouldn't serve as a title or headline for your letter. Even worse, generic subjects such as "here ya go" are worthless both in the inbox and in a folder when the recipient searches for it later. Don't try to squeeze your whole message in the subject line, either.
4. **Putting too many people in the "To" or "CC" line:** Include only those to whom you are directly speaking in the "To" line. Others with clear interest should be copied in the "CC" field. Use some discretion; don't add people unless they truly need to know.
5. **Using improper greetings:** Email generally falls between formal and casual. A "To whom it may concern" is probably over the top, but "Hey" or similar is too casual. Many experts prefer a simple "Hi, John."
6. **Not introducing yourself:** When you don't know the recipient already, be sure to introduce yourself clearly and simply at the beginning. Write something like, "My name is John. I'm the HR Director at Main Street Clinic."
7. **Using too many exclamation marks(!):** You can show your enthusiasm and cheerfulness by ending a greeting with an exclamation point ("Good morning!), but in the body of your text, you might be misunderstood. Instead of "I need it ASAP!" try dialing it back to "How soon can you have it to me? This is quite urgent."
8. **Not starting your email with the most important information:** You're not writing a suspense novel with the climax at the end. Get right down to business and state the most important thing right away. Many people skim through emails and might miss the main point if you bury it several lines in.
9. **Using slang abbreviations:** Leave "LOL," "IDK," and "BTW" in your phone texts. You can use business abbreviations that have become standard in written communications ("FYI" or "EOD"), but err on the conservative side if you're not sure.
10. **Using a rude tone:** Avoid sarcasm or any phrasing that would rely on your vocal tone or facial expression to be properly understood. Remember that email is becoming the primary documentation for later inquiries (and even legal action) these days. Write straightforwardly and clearly.
11. **Communicating via email when you should be doing it over the phone (or face-to-face):** Often, it's better to pick up the phone or walk down the hall to discuss issues and concerns with a coworker. Remember that once you click "send," you've lost total control of whatever you said in the email and/or copies thereof.

Source: Shelby Skrhak, CNBC Make It, February 26, 2019; https://www.cnbc.com/2019/02/26/11- annoying-email-mistakes-that-can-drive-your-co-workers-and-bosses-crazy.html

EMPLOYMENT LAW

Boost in Union Organizing Activity and Membership

During the COVID-19 pandemic crisis, many "front-line" workers performing essential functions regularly raised concerns about inadequate equipment, protective procedures, and lack of management attention or concerns about their safety. When protective equipment was not forthcoming and people perceived lack of action and concern, they began to have collective upset. They began to turn to a ready source of support—unions. Workers in healthcare, grocery stores, ambulance services, food processing, delivery services, and more have apparently reached out to unions, which were ready and willing to act. Union lobbying was in part responsible for agencies such as OSHA and state health/safety authorities to start implementing enhanced safety rules, and

for a number of employers to seem to pay more attention to these issues. This may well have a lasting effect. After years of declining union membership and apparent worker disinterest over wage-and-hour bargaining, personal safety may have triggered a new interest for collective action and may result in a surge in union organizing.

Source: Boardman Clark Labor & Employment Law Update, May 2020

Bang the Gong Softly!

A state court issued an injunction against striking hospital workers who were loudly and repeatedly banging two large metal gongs outside the hospital to draw attention to their dispute. The gongs started at dawn and carried on throughout the day, for days on end, at a decibel level between 80 and 105 decibels. A 105-decibel level is "the equivalent of a loud rock concert," which can cause hearing damage within as little as five minutes. The constant gonging drew complaints from patients, their families, other hospital employees, and neighboring businesses and residents. The hospital filed for and was granted an injunction to stop the gong show since the noise was disturbing to the patients and their health.

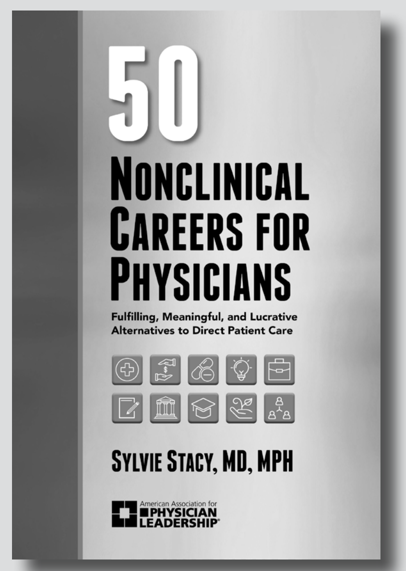
***Marin General Hospital v. Int. Union of Operating Engineers Local 39* (Ct. App. Cal., 2020)**

PTSD Did Not Justify Profane Outbursts and Throwing Things at Co-Workers.

The dismissal of an Army veteran's Americans with Disabilities Act case was upheld. The Vet was fired from a call center job after incidents of outbursts in which she cursed and threw objects at co-workers. She claimed that these incidents were due to her service-related post-traumatic stress disorder disability, and that other employees had engaged in inappropriate behavior, yet not been discharged. The court ruled that an employer can require all employees to follow rules of civil and safe conduct; a disability does not excuse one from these basic standards. Further, the company had fired other nondisabled employees for similar behaviors. The individuals the plaintiff cited as "comparators" were not similarly situated as they had engaged in milder, purely verbal incidents of snarky emails or curt, irritated "snapping" at others, which were significantly less severe in comparison.

***Trehan v. Wayfair Maine LLC* (1st Cir., 2020)**

50 Nonclinical Careers for Physicians: Fulfilling, Meaningful, and Lucrative Alternatives to Direct Patient Care by Sylvie Stacy, MD, MPH



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By the time they realize their career in clinical medicine isn't everything they thought it would be, many physicians believe they're too invested in their trade to turn back now. Feeling burned out, disengaged, unfulfilled or burdened by high student debt or compensation incommensurate with the demands of their job, they may feel trapped, without options and with nowhere to turn.

In her book, preventive medicine physician Sylvie Stacy offers physicians an escape from that bleak "trap" by identifying numerous nonclinical career options that could align with their skillsets and individual financial situation.

The Next COVID-19 Stimulus Package and the 2020 Election

Erica Lindquist, MBA*

The year is already half over, and the COVID-19 pandemic still plagues the United States. Case numbers continue to surge, as well as deaths, showing no signs of slowing down. At the time of drafting this article, the total number of confirmed COVID-19 cases in the United States has reached over 4.2 million. The number of deaths has surpassed 146,000.[1] Currently, the United States is in an economic crisis with unemployment at 11.1% on July 2, 2020.[2] Given the continued healthcare crisis, Congress continues to develop and negotiate a fourth stimulus plan that provides economic relief and focuses on three main areas: education, employment, and healthcare workers.

While the Senate's stimulus package is not yet released, following are the proposed items most likely to be included[3]:

- A second round of direct payments, likely $1200 per person, if you fall within the designated income range;
- Reduced unemployment benefits, likely $200 per week for a short period, then 70% of previous wages;
- A second round of Paycheck Protection Program loans that target the hardest-hit small businesses;
- $105 billion in educational funds with $70 billion allocated for K-12 schools, $30 billion for colleges and universities, and $5 billion for governors;
- $16 billion, plus an additional $9 billion unused funds from the CARES Act, for state testing grants;
- $26 billion for vaccine research and distribution;
- $15.5 billion for the National Institutes of Health; and
- Liability protections to create a safe harbor for businesses, nonprofits, schools, and medical providers to protect against litigation related to COVID-19.

The anticipation is that the primary points of negotiation between the Democratic and Republican parties will surround the unemployment benefits, liability protection for businesses, and additional financial aid for state and local governments.[4] The Senate and House hope to reach an agreement and finalize the stimulus bill before July 31, but at the latest by August 7, 2020.

Many hospitals are still facing significant financial hardships related to the COVID-19 pandemic. On July 17, 2020, the U.S. Department of Health and Human Services (HHS) announced it would begin to distribute a second round of $10 billion high-impact COVID-19 area funding to hospitals to assist in areas with the most need as the pandemic evolves.[5] This assistance is part of the Provider Relief Fund, which was a $175 billion designation from the CARES Act. In addition to the general distribution of $50 billion, HHS had previously distributed $12 billion of high-impact funding to 395 hospitals. It has also opened the application period to allocate $15 billion to eligible providers that participate in state Medicaid and CHIP programs that have not yet received payments from the general distribution of the Provider Relief Fund program.

As of July 23, 2020, HHS has extended the COVID-19 public health emergency designation for another 90 days.[6] This allows any policies, funding, and relief tied to the emergency declaration to be extended. This includes the relaxed telehealth restrictions that have been in place to provide patients access to providers during the COVID-19 pandemic. It also allows for the continuation of the 20% Medicare inpatient add-on payment for COVID-19 patients, and increased federal Medicaid matching funds for states.

The election and the pandemic tend to take over the focus of the legislative and executive branches, with little movement on policy unless used as an election campaign tactic.

The COVID-19 pandemic will inevitably change the way healthcare is provided across the United States. This, in turn, will impact healthcare legislation, which typically tends to slow down the closer it gets to a presidential election. The three central policies that have been hot topics are drug-pricing reform, adjustments to Medicare Part D, and surprise billing. While discussion on these policies continues, the election and the pandemic tend to take over the focus of the legislative and executive branches,

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with little movement on policy unless used as an election campaign tactic.

Whoever wins the presidency in November will impact healthcare policies and regulations going forward.

With less than 100 days until November 3, 2020, understanding each candidate's plan for healthcare is an integral part of an individual's decision on which candidate to vote for. The pandemic has affected millions of Americans, and some have lost insurance coverage or can no longer afford the coverage that they have. Candidate Joe Biden[7] is running on the platform that every American should have access to affordable health insurance by building on the Affordable Care Act (ACA). At this time, President Donald Trump has not released his plan for healthcare, other than to repeal the ACA, of which he has been unsuccessful thus far in his presidency.

We can be sure that whoever wins the presidency in November will impact healthcare policies and regulations going forward, with significant impacts on Medicaid coverage and immigration. The focus on transforming Medicaid will potentially lead to millions of adults and children losing health coverage because of imposed work requirements and increased eligibility reviews.[8] This can subsequently impact the reimbursement of care provided at children's hospitals through an increase in uncompensated care for uninsured or indigent patients. One thing we can count on is that the move to value-based care will continue, no matter who wins the election.

REFERENCES:

1. Coronavirus disease 2019: cases, data, and surveillance. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html. Accessed July 27, 2020.
2. The Employment Situation – June 2020. Bureau of Labor Statistics. https://www.bls.gov/news.release/pdf/empsit.pdf. Accessed July 27, 2020.
3. Stimulus negotiations: GOP's $1 trillion opening bid would cut unemployment benefits. July 27, 2020. CNN Politics. https://www.cnn.com/2020/07/27/politics/stimulus-negotiations-republican-plan/index.html. Accessed July 27, 2020.
4. Wang J. Next stimulus package showdown: three key conflicts in the next stimulus bill. Forbes. July 25, 2020. https://www.forbes.com/sites/jimwang/2020/07/25/next-stimulus-package-showdown-the-three-key-conflicts-in-the-next-stimulus-bill/#2bdd9c8238d8. Accessed July 27, 2020.
5. HHS to begin distributing $10 Billion in additional funding to hospitals in high-impact COVID-19 Areas. U.S. Department of Health and Human Services. July 17, 2020. https://www.hhs.gov/about/news/2020/07/17/hhs-begin-distributing-10-billion-additional-funding-hospitals-high-impact-covid-19-areas.html. Accessed July 23, 2020.
6. HHS officially renews public health emergency for COVID-19. July 23, 2020. Modern Healthcare. https://www.modernhealthcare.com/politics-policy/hhs-officially-renews-public-health-emergency-covid-19. Accessed July 27, 2020.
7. Health Care. Joe Biden. https://joebiden.com/healthcare/. Accessed July 27, 2020.
8. Taking away Medicaid for not meeting work requirements harms children. Center on Budget and Policy Priorities. March 10, 2020. https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-children. Accessed July 22, 2020.

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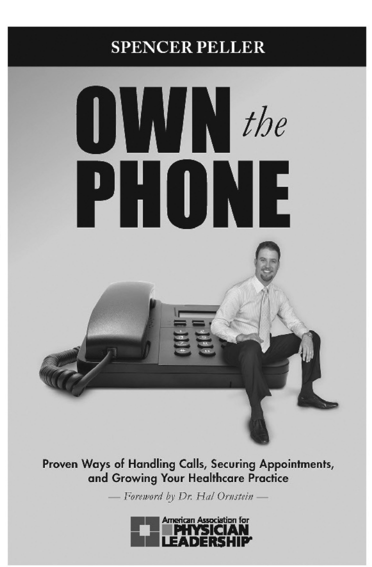

Improving Patient Access to Primary Care with Open Access Scheduling

Kelli A. Grambeau, DNP, FNP-C*

Timely access to primary care is a major issue in the United States. Poor access to primary care results in a large number of patients seeking care in urgent care settings. A quality improvement initiative was conducted with a primary objective to reduce time to third next available appointment (TNAA) while decreasing the number of patients referred to urgent care. A primary care practice was utilized for implementation. The policy for open access scheduling (OA) was developed in collaboration with the providers and clinical staff at the practice. Pre- and post-implementation data were collected on TNAA and urgent care referral numbers. These were evaluated along with a secondary outcome of patient satisfaction. The quality improvement project resulted in a decrease in time to TNAA and urgent care referrals. Despite this improvement, there was no clinically significant improvement in patient satisfaction.

KEY WORDS: **Primary care; third next available appointment; open access scheduling; advanced access scheduling; urgent care referrals; quality improvement; patient satisfaction.**

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In the United States, many primary care offices are affected by an overwhelming patient demand due to primary care provider shortages.[1] The average wait time for a new routine visit with a family practice provider is 24 days.[2] As a result, patients often receive nonurgent care from emergency departments and urgent care centers, which can cause a disruption in continuity of care, as well as decreased revenue for the primary care practice.[1] Studies show that a large portion of these patients (10%–60%) can be managed using primary care.[3] Treatment in the urgent care setting often is delivered without the conveniences of a complete medical history, or the capability to ensure follow-up, which results in episodic and fragmented care.[4] Timely access to primary care can reduce health disparities, improve health outcomes, reduce emergency department and urgent care visits, and, ultimately, decrease the cost of healthcare.

The urgent care center is not an optimal setting for patients to receive primary care, because it is less cost efficient.[4] In 2020, the average cost for an urgent care visit for acute primary care diagnoses such as acute otitis media, pharyngitis, or a urinary tract infection is $155. A visit to the emergency department costs approximately $1233, with the average copay being $50 to $100. In contrast, a copay for a primary care office visit is an average of $15 to $25, and the cost of an established, Level 3 patient visit averages $104.[5] Due to barriers such as limited office hours and limited same-day availability in primary care, patients often seek alternate forms of care.[6]

Access to primary care commonly is measured by the third next available appointment (TNAA).[2] TNAA is considered a more accurate way to measure, because the first and second available appointments usually are last-minute openings that became available as a result of patient cancellations.[1]

To address the modifiable barriers to access of primary care, evidenced-based literature supports the use of open access or same-day scheduling.[7] According to the Institute for Healthcare Improvement,[8] the third next available primary care appointment should be zero days (i.e., same day) to ensure timely access to care. The purpose of this quality improvement project was to improve same-day patient access in a primary care setting using evidenced-based open access (OA) scheduling.

THE PROBLEM

A Northwestern U.S. family practice's TNAA was an average of 22 days. This was above the practice goal of zero to five days and far above the national benchmark of zero days.[8]

This delay in access to primary care resulted in an office average of 22% of patients per month being referred to urgent care. One of the modifiable barriers this practice faced was the practice's current scheduling process, which had a daily designated "on-call" provider for same-day appointments. These appointment slots were being filled weeks and even months in advance. Patient satisfaction also was affected. Only 58% of patients rated ease of scheduling an urgent appointment as excellent. Additional barriers to timely access to primary care included provider shortages, high volume of patients with chronic conditions, and no after-hours availability.[9]

OPEN ACCESS SCHEDULING

To address the modifiable barriers to access of primary care, evidenced-based literature supports the use of open access or same-day scheduling.[7] Advanced access scheduling—also referred to as *open access* or *same-day scheduling*—is one of the most feasible and economical approaches to improve access to primary care appointments.[7] OA scheduling focuses on reducing and eliminating delays without adding additional staffing resources.[7]

About 65% to 75% of the provider's schedule is completely open at the start of the day. Office staff offer an appointment to the patient on the same day he or she calls. Appointment lengths are standardized to 15- to 20-minute acute visits.[7]

EVIDENCE REVIEW

Several studies in the literature have addressed the topic of improving patient access to care and offer information on OA scheduling to decrease time to TNAA. A systematic review by Ansell et al.[7] looked at 11 studies focused on this outcome. Overall, the researchers found that there was a mean reduction in wait time of 11.3 days when OA scheduling was implemented.[7] A pilot study by Bundy et al.[10] consisted of four primary care clinics in North Carolina that expressed interest in quality improvement (QI) and implemented OA scheduling. The average time to TNAA was decreased from 36 days (95% confidence interval (CI): 20, 44 days) to 4 days. In addition to a decrease in TNAA, patient satisfaction increased by 16%, from 45% to 61% (95% CI: 0.2%, 30%).[10] Mallard et al.[11] conducted a pilot study to assess the implementation of OA and its effect on patient wait time, no-shows, new patient appointments, and provider productivity. The average wait time for TNAA was 46 days. After initiation of same-day scheduling, the time to TNAA decreased to 5 days ($p < .0001$).[11]

Mehrotra et al.[1] conducted a case series including five primary care practices to assess the effect of OA scheduling on time to TNAA, no-show rates, and patient satisfaction with appointment availability. After four months of OA scheduling, the average time to TNAA for all five practices decreased from 21 days to 8 days for short visits and from 39 to 14 days for long visits.[1]

A qualitative analysis performed by Dixon et al.[12] evaluated the impact of advanced access scheduling on patient access to primary care. Time to TNAA with a provider decreased by almost 60%, from 3.6 to 1.5 days.[12] Cameron et al.[2] performed a QI project to implement OA scheduling to decrease time to the TNAA. Data were collected nine months pre-implementation and nine months post-implementation. Following the implementation of OA scheduling, time to TNAA decreased from a mean of 13.7 days to 3.6 days ($p < .0001$).[2]

METHODS

Ethical Review

This project was evaluated by the Medical University of South Carolina's institutional review board (IRB) guidelines for quality improvement. IRB submission was not required for this project, because as it was designated as a certified QI project. There was no increase in patient risk, and HIPAA guidelines were maintained throughout the data collection process. Patient information was depersonalized and maintained on a password protected-computer.

Study Design

This quality improvement initiative was based on pre- and postintervention data. Pre-intervention data were collected from April 2019 to July 2019. Post-intervention data collection ran from August 2019 through February 2020. Primary data collected were on time to TNAA and percent of urgent care referrals monthly.

Translational Framework

The RE-AIM (reach, effectiveness, adoption, implementation and maintenance) framework was highly applicable to this project, because it is widely used in quality improvement projects. Use of this framework helped translate research into practice in a systematic and organized manner. Buy-in from providers and staff was secured and maintained by frequently meeting with providers, administration, and office staff to address barriers or concerns. Data were presented to key stakeholders on the intervention and its success at monthly provider meetings, helping to improve the project's sustainability.[13,14]

Setting and Population

The clinical site was a primary care practice with a broad patient population. Staff consisted of six physicians, one nurse practitioner, and two physician assistants. The population setting for this project included all patients who were calling to request a same-day appointment. The patients were primarily Caucasian, ranging in age from newborn to elderly, with acute and chronic illnesses. The

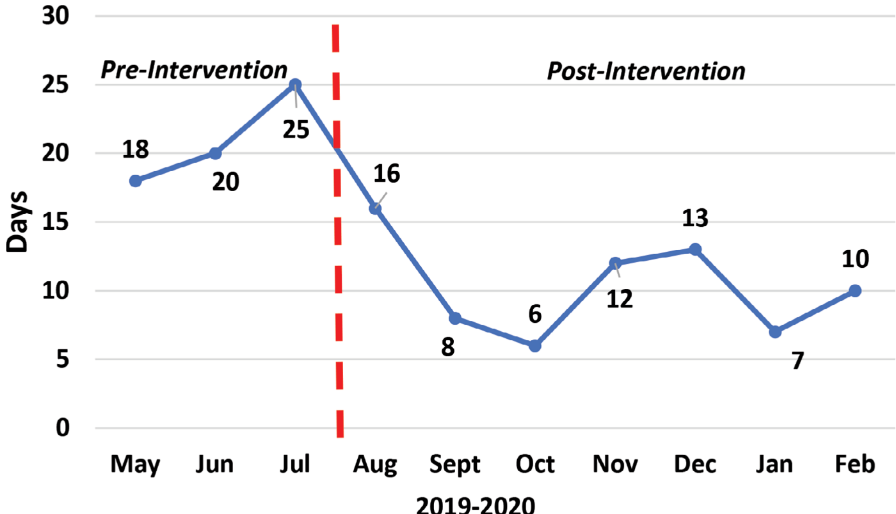

Figure 1. Third next available appointment. Office average pre- and post-intervention.

office receives an average of 100 calls per month requesting same-day appointments.

INTERVENTION

An OA schedule policy was developed in collaboration with the clinic's providers, administration, and the project coordinator. The policy initially included keeping 50% of each day's appointment slots open for the on-call provider; however, two months into implementation, 50% of these appointments opened three days prior and the remaining 50% opened the morning of to accommodate subacute and acute needs. The OA slots for the daily on-call provider were intended for urgent or acute needs and were not to be used for routine or chronic visits. This was a change from the previous scheduling process, in which the on-call provider's schedule was already fully scheduled on most days.

Education for staff was provided by the project coordinator via PowerPoint presentation. Patients were educated on the new scheduling process via flyers, text messages, and email reminders. Implementation occurred over seven months, with data collection weekly. Meetings with staff and key stakeholders initially took place biweekly to gain feedback, address concerns, and discuss progress, and then progressed to monthly.

MEASURES AND DATA COLLECTION

The primary outcomes were reductions in urgent care referrals and in TNAA. The secondary outcome was to improve patient satisfaction regarding ease of scheduling an urgent appointment. Urgent care referrals were tracked within the EHR. The outcome of each call received by the triage nurse was followed and documented. TNAA was tracked by the project coordinator. Once weekly, the number of days between a request for an appointment with a provider and the TNAA with that provider was counted. The TNAA appointment was calculated for each provider and then averaged to make up the total practice TNAA. The practice site's patient satisfaction survey, consisting of 12 questions, was provided via email to every patient after each appointment.

The time to TNAA was compared pre- and postintervention (Figure 1). The postintervention TNAA was tracked weekly to assess for trends. An additional primary aim was to decrease the number of patients referred to urgent care. Postintervention urgent care referrals were tracked biweekly, comparing pre- and postintervention via the EHR (Figure 2). A secondary aim was to improve patient satisfaction regarding ease of scheduling urgent or same-day appointments. The pre- and postintervention response to the patient satisfaction survey regarding ease of scheduling urgent appointments was tracked. The following descriptive information was collected: number of patient calls requesting same-day appointment; reason for appointment; outcome of call; and patient's primary provider.

RESULTS

A total of 898 calls were evaluated, pre-intervention (n=189) and post-intervention (n=709). Significant improvements were seen in time to TNAA and number of urgent care referrals. Patient satisfaction improvements were not clinically significant. The average time to TNAA decreased from 22 days to 10 days postintervention. Percent of patients referred to urgent care also decreased, from 22%

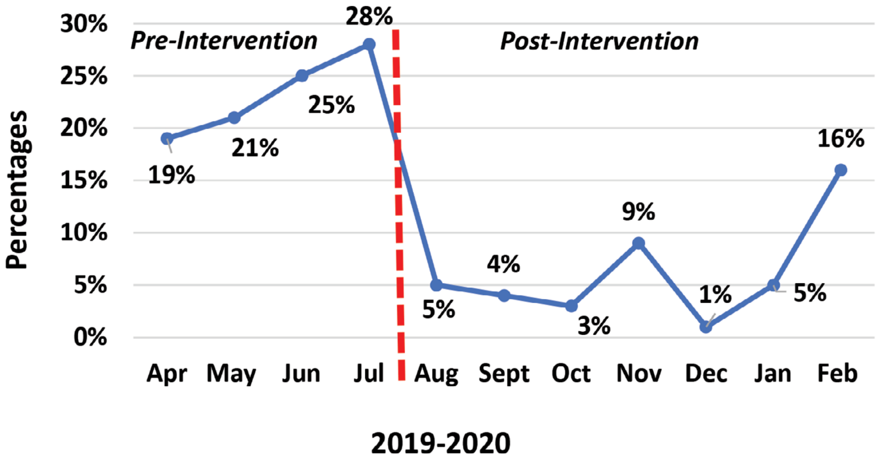

Figure 2. Urgent care referrals pre- and post-intervention.

to 6% monthly. Patient satisfaction regarding ease of scheduling an urgent appointment increased slightly, from 58% to 59%. This increase may have been affected by an increase in patient response rate to this question postintervention.

DISCUSSION

Despite the extensive healthcare system in the United States, wait times to see a primary care provider are still delayed, with an average of 24 days. These delays lead to patients seeking care in urgent and emergent settings, increased health care costs, decreased patient satisfaction, decreased continuity of care, and negative effects on healthcare outcomes.[1,3,7] OA scheduling has been shown to be a cost-effective way to reduce time to TNAA.

This quality improvement project focused on decreasing time to TNAA and reducing the number of patients referred to urgent care. The project demonstrated that use of a modified version of OA scheduling can accomplish both goals. Time to TNAA decreased from 22 days to 10 days after the seven-month intervention period. Urgent care referrals decreased from 22% to 6% per month. The improvement in access to care had a great impact on the clinic's patients. The reduction in time to TNAA is similar to that of other studies that have been performed in family practice settings. There is a high probability for sustainability due to the length of the postintervention. Over a period of seven months, a total number of 898 phone calls were received from patients requesting an appointment for acute needs, and staff and providers were receptive to the intervention.

LIMITATIONS

This project may not be applicable in all family practice settings. This specific clinic designates one physician each day to be the "on-call" provider. Information from the literature was applied to the "on-call" physician's schedule. Differing scheduling practices may affect the generalizability of this project. Secondly, new front desk staff were hired during the intervention period who were not familiar with the new scheduling process. Frequent education was provided to compensate for changes in staffing. A third limitation was that a new provider was hired at the start of the intervention period. This provider's availability may have improved the office average for time to TNAA.

CONCLUSION

Implementing a modified version of OA scheduling decreased the time to TNAA and the number of patients referred to urgent care. However, the time to TNAA is still above the office goal. It will be beneficial to continue to trend and monitor the number of calls received each month and adjust open slots accordingly. Making more open slots available during the cold and flu season and less during the months where not many same-day appointments are needed will be most cost efficient. New staff hired to work the front desk should be well trained in the scheduling process to ensure open slots are used appropriately. Evidence-based interventions intended to reduce time to TNAA and reduce urgent care referrals should be used to increase access to care, improve continuity of care, decrease health care costs, and improve patient outcomes. Further research is needed to look specifically at urgent care referrals that are the result of a lack of access to primary care.

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REFERENCES

1. Mehrotra A, Keehl-Markowitz L, Ayanian JZ. Implementation of open access scheduling in primary care: a cautionary tale. *Ann Intern Med.* 2008;148:915-922.
2. Cameron S, Sadler L, Lawson B. Adoption of open-access scheduling in an academic family practice. *Can Fam Physician.* 2010;56:906-911.
3. Coster, JE, Turner JK, Bradbury D, Cantrell A. Why do people choose emergency and urgent care services? A rapid review utilizing a systematic literature search and narrative synthesis. *Acad Emerg Med.* 2017;24:1137-1149.
4. Weisz D, Gusmano MK, Wong G, Trombley J. Emergency department use: a reflection of poor primary care access? *Am J Manag Care.* 2015;21(2):e152-e160.
5. Fay B. Doctor's visit costs. Debt.org. 2019. www.debt.org/medical/doctor-visit-costs/. Accessed April 3, 2019.
6. Villasenor S, Krouse HJ. Can the use of urgent care clinics improve access to care without undermining continuity in primary care? *J Am Assoc Nurse Pract.* 2016;28:335-341. DOI: 10.1002/2327-6924.12314
7. Ansell D, Crispo JA, Semard B, Bjerre LM. Interventions to reduce wait times in primary care appointments: a systematic review. *BMC Health Serv Res.* 2017;17(295). DOI 10.1186/s12913-017-2219-y.
8. Third next available appointment. Institute for Healthcare Improvement. www.ihi.org/resources/Pages/Measures/ThirdNextAvailable-Appointment.aspx.
9. Corscadden L, Levesque JF, Lewis V, Strumpf E., Breton M, Russell G. Factors associated with multiple barriers to access to primary care: an international analysis. *Int J Equity Health.* 2018;17(28). doi.org/10.1186/s12939-018-0740-1.
10. Bundy DG, Randolph GD, Murray M, Anderson J, Margolis PA. Open access in primary care: results of a North Carolina pilot project. *Pediatrics.* 2005;116:82-87.
11. Mallard SD, Leakeas T, Duncan WJ, Fleenor ME, Sinsky RJ. Same-day scheduling in a public health clinic: a pilot study. *J Public Health Manag Pract.* 2004;10:148-155.
12. Dixon S, Sampson FC, O'Cathain A, Pickin M. Advanced access: more than just GP waiting times? *Fam Pract.* 2006;23:233-239.
13. RE-AIM. What is RE-AIM. www.re-aim.org/about/what-is-re-aim/
14. White K, Dudley-Brown S, Terhaar M. *Translation of Evidence Into Nursing and Health Care,* 2nd ed. New York: Springer Publishing Company; 2016.

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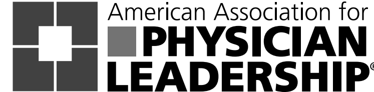

Introduction to Value-Based Reimbursement: How to Get Started

Grace E. Terrell, MD, MMM, CPE, FACP, FACPE,* and Julian D. "Bo" Bobbitt Jr., JD†

As value-based integrated population health, headlined by Accountable Care Organizations (ACOs), approaches a decade of evolution, value-based payment will become the dominant form of healthcare payment. Although the move to value will take many forms, ACOs are considered one of the prime vehicles to accomplish this change.

KEY WORDS: ACO; payment models; reimbursement; value-based payment value-based care health policy.

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With more than 1000 Accountable Care Organizations (ACOs) in existence today and, at last count, 32.7 million patients enrolled in ACOs, several documented successful strategies have emerged.[1] Up to half of the U.S. population may be served by ACOs within the next five years.[2]

HOW DID WE GET HERE?

If we stay on the current spending glide path, by 2035, healthcare costs in this country will amount to more than the total of all tax and other revenues collected, and by 2080, taxpayer-funded healthcare will equal all of our governmental revenues, meaning that everything else—defense, roads, education—must be funded by borrowing. In a 2014 report by the Commonwealth Fund, the United States "ranked last overall among 11 industrialized countries on measures of health system quality, efficiency, access to care, equity, and health lives." Significantly, the United States was noted to have the highest costs while also displaying the lowest performance.[3]

> *The U.S. healthcare delivery system is undergoing a paradigm shift based on payment reform intended to drive value and improve the quality of care.*

The Congressional Budget Office laid the groundwork for accountable care's "pay-for-value" underpinning when it reported that much of the blame for our runaway healthcare costs should be placed on our fee-for-service payment system where "providers have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists."[4]

The U.S. healthcare delivery system is undergoing a paradigm shift based on payment reform intended to drive value and improve the quality of care. This "volume-to-value revolution" is designed to reward those best able to provide efficient, high-quality services. Value-based business models require providers to undergo transformative organizational change to every facet of their operations. Reimbursement based on outcomes and taking on financial risk necessitates investment in clinical integration, redesign of traditional patient care models, and integrated information technology. Provider organizations that adequately invest in population health management capabilities and successfully shift to value-based contracts and capitated payments will have the greatest likelihood of success in the transformed healthcare market.

Payers, including Medicare, are pushing providers for increased accountability for the quality and cost of care delivered. Ongoing governmental policy changes since 2015 have greatly accelerated the healthcare market's move from pure fee-for-service to value-based reimbursement. In 2015, Department of Health and Human Services Secretary Burwell announced the department's goal was to move 50% of Medicare payments to value-based payment models by 2018; this goal was accomplished prior to the transition from the Obama to the Trump administration.

The Medicare Access and CHIP Reauthorization Act (MACRA) legislation further accelerated the broad move of the U.S. healthcare industry toward paying for medical

services based on value rather than volume. The sustainable growth rate formula for physician payments was replaced with a fundamental shift to performance-based payments, with fee-for-service payments adjusted based on quality and cost through the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs) focused on population-level quality and outcomes performance that involve significant financial risk, but provide substantial bonus payments for those physicians who are in APMs rather than the modified MIPS fee-for-service based payment system.

Providers participating in qualified APMs will have a 5% basic bonus in Medicare fee rates from 2019 to 2024 and will not be subject to the penalties for poor performance in MIPS, which will increase over a five-year period to 9% reduction in fees.

Furthermore, organizations can qualify under MACRA for APM bonus payments by moving their non-Medicare patients to APMs, not just by changing how they receive payment for Medicare patients.

Over the next few years, these policy changes will greatly accelerate the transition of the healthcare delivery system to one differentiated by performance at the global system level. The ACO-covered lives are projected to increase from the current 37 million lives to 177 million lives by 2020—a more than 600% increase.[5]

As reimbursement moves from volume-based to value-based, the department-centered organizational model of most legacy healthcare providers must be reorganized around specific populations, conditions, and focused asset capabilities.

The 21st Century Cures Act enacted by Congress in December 2016 further accelerated federal healthcare payment reform via its emphasis on reducing administrative burden for providers addressing health information technology barriers, such as information blocking, interoperability, and the expansion of telehealth services. Current CMS Administrator Seema Verma continues to emphasize the reduction in regulatory burden and flexibility while also focusing policy on increasing incentives for providers to assume more risk in value-based payment models. In January 2019, she announced CMS is exploring ways to apply value-based payment models beyond Medicare and encourage more providers to buy into the programs and work with additional payers. The Trump administration, like the Obama administration before it, is committed to the transition to value-based care. The administration is pushing the envelope to accelerate the progression of contracts from shared savings to full capitation with market-based reforms emphasizing individual choice, decreased regulatory burden, and increased competition.[6]

Healthcare providers need a new set of skills and tools to successfully navigate this accelerating transition. As reimbursement moves from volume-based to value-based, the department-centered organizational model of most legacy healthcare providers must be reorganized around specific populations, conditions, and focused asset capabilities. Efficiency on a population level rather than volume-based unit level will become increasingly important for financial viability, with chronic condition management, "focused-factory" capabilities for bundled payments, and service offerings organized around specific patient populations driving profitability more significantly than investment solely in capacity. Strategic alliances across the continuum of care and investment in clinical and information integration will become increasingly important drivers of profitability.

The resources and capabilities necessary in reforming the healthcare delivery system are inadequate for the demand as the fee-for-service system shifts to value-based payment models. Proven models for success and adequate infrastructure are in short supply because the capabilities involving strategy, people, process, and technology required for the new delivery system paradigm are not intrinsic in current healthcare organizations' structural framework, which has been built to maximize success in the fee-for-service payment system.

Given that governmental and commercial payers are moving to a value-based model of reimbursement over the next two to five years, it is remarkable that 95% of health provider organizations in the United States have no specific strategy for moving to that model. Even though physician reimbursement will increasingly be based on quality outcomes and patient satisfaction, there are few holistic, physician-inspired solutions that will support the people, process, and technology transitions required to lower operating costs and increase the quality of care.

The solution is to change the culture of the care team through innovative and proven care model redesign, reduce healthcare operating costs by providing process and technology tools to dramatically increase productivity and efficiency, and increase healthcare operating margins by providing process and technology tools to manage contracts and risk.

Because most patient populations require a full suite of healthcare services, providers must be able to enter into strategic partnerships with internal and external stakeholders across the entire spectrum of the healthcare delivery system network. Future integrated delivery networks will be focused around care models that operate at the intersection of the population segments and health conditions. New

structures, such as internal care coordination and condition management hubs, clinically integrated networks (CINs), and high-performance networks (HPNs) will be required to provide the quality, breadth, and efficiency of healthcare services being demanded by the new paradigm.

THE NEW HEALTHCARE IS A TEAM GAME

Building on the momentum of other growing trends toward changing payments to incentivize better population health and lower costs such as the Medicare Shared Savings Program (MSSP) and MACRA will radically change America's healthcare delivery landscape. The transformation of the delivery model has been progressing in recent years from fee-for-service (which has had the unfortunate unintended consequence of paying more money for more, not better, care) to pay-for-value (which rewards better outcomes at lower cost). However, to a large degree, the transformation has been implemented slowly. MACRA has fixed deadlines and significant financial bonuses and penalties and should not only significantly impact provider Medicare fee reimbursement but motivate other payers to shift as well.

A fundamental premise of value-based care is to achieve better health status and reduce avoidable overall costs for patient populations. This is almost impossible to achieve if providers continue practicing in silos, within a fragmented and uncoordinated "non-system." Put another way, practicing in integrated care teams is the proverbial low-hanging fruit in the new healthcare to drive "value," defined here as achieving the highest quality at the lowest costs.

Surveys show that the majority of affected providers with substantial Medicare beneficiary populations are totally or mostly unfamiliar with MACRA.[7] Anecdotally, it is clear that even fewer comprehend that the now-delayed "cost" measurement on which they will be graded within its MIPS and Advanced APM components of MACRA will generally judge them on the overall costs for the patients they encounter, not just their own costs.

The "accountable" part of accountable care organization denotes that all providers now depend on each other, across specialties, to manage the health status and total overall costs of their patient populations.

This is as radical as it is poorly understood. For example, as Mark McClellan, MD, PhD, wrote recently, although a primary care physician receives 6% to 8% of this sum, the patients of a typical primary care physician in this country consume roughly $10 million annually in healthcare costs.[8] The MSSP, MACRA MIPS, and advanced APMs models clearly require and incentivize coordinated care across the care continuum. The impact of MACRA virtually guarantees that value-based payment will be a dominant payment model.

Other private and public payment initiatives like accountable care organizations continue to grow as well. For example, the "accountable" part of accountable care organization denotes that all providers now depend on each other, across specialties, to manage the health status and total overall costs of their patient populations. No longer is doing well as an individual enough.

The bottom line is that the influence of MACRA removes all doubt that value care is inevitable and that thriving in such an environment, where providers are compensated based on the overall costs of their patients, requires interaction across specialties. The new healthcare is a team game.

THE MOVE TO VALUE IS NOT GOING AWAY

MACRA was passed by both chambers of Congress with strong bipartisan support.[9] Implementing regulations have now been promulgated by both the Obama and Trump administrations.[10] HHS Secretary Alex Azar's announcement of five new value-based primary care payment models on April 22, 2019 integrates direct input from primary care clinician stakeholders and is based on underlying principles designed to reward value and quality[11]:

- Prioritizing the doctor-patient relationship;
- Enhancing care for patients with complex chronic needs and high need, seriously ill patients;
- Reducing administrative burden; and
- Focusing financial rewards on improved health outcomes.

Importantly, the five primary care models introduced are designed for primary care physicians in practice types across the organizational spectrum, from small, independent practices to integrated delivery networks. Primary Care First is designed for physicians in small, independent practices, whereas the direct contracting models are designed for ACOs, IDNs, and Medicare Advantage plans. These ambitious programs are designed to move 25% of Medicare patients out of the fee-for-service arrangement with primary care physicians and into value-based payment models.

Similarly, on July 10, 2019, HHS Secretary Azar and CMS Administrator Verma announced five new payment models focused on nephrologists and designed to transform kidney care: the End-Stage Renal Disease Treatment Choices Model; the Kidney Care First Model; and variations of the Comprehensive Kidney Care Contracting Models (Graduated, Professional, and Global). They also announced a

proposed Radiation Oncology Model targeted to radiation therapy providers. These models are a harbinger of value-based care focused on specialists.

CHANGE IS HARD

Without question, we are moving to a team-oriented value-based payment model for integrated population health. This will require a disruptive transformation of healthcare delivery. Such a fundamental change is difficult for people and organizations, and there is a natural tendency to resort back to fee-for-service business practices even once in an integrated or alternative arrangement. Additionally, change is difficult even when there is universal support, which this movement has never purported to have.

The move to value is an opportunity for physicians and other health system leaders to drive positive change and create a sustainable, affordable healthcare delivery system. The so-called healthcare Triple Aim is based on the idea of delivering the right care at the right time at the right price. We should all embrace with enthusiasm the unprecedented opportunity to redesign the healthcare system to achieve these aims. These new payment models are the opening for physicians and other healthcare leaders to think about new and better ways of providing healthcare services and participate in the redesign opportunity of a lifetime.

A new set of skills is required for physician and other healthcare leaders to accomplish this goal. These skills include a working knowledge of design thinking and change management and an understanding of the new payment models and contracting parameters. Those who will be most successful in the move to value will be those who bring these new skills to the table in a way that integrates the vast expertise in patient care delivery already part of our skill set.

There is no way to thrive under the new model without collaborating and "integrating," as it were, with other providers; moving to value care is no longer optional.

Value-based care done right is truly disruptive. It requires a major culture shift by stakeholders and a major reengineering of care delivery. It is no surprise that the most successful ACOs are the ones that have been at it the longest. Richard Zane, MD, while serving on the NEJM Catalyst Insights Council, stated, "I feel our current system of healthcare is so flawed and rife with anchoritic processes and perverse disincentives that the only likely way we'll achieve the transformation is through disruption. . . .

[O]ut-of-the-box thinking is difficult for entrenched health systems because many are totally hooked on fee-for-service medicine."[12]

REFERENCES

1. Muhlestein D, Saunders RS, Richards R, McClellan MB. Recent progress in the value journey: growth of ACOs and value-based payment models in 2018. Health Affairs Blog. August 14, 2018. www.healthaffairs.org/do/10.1377/hblog20180810.481968/full.
2. Leavitt Partners. https://leavittpartners.com.
3. The Commonwealth Fund. US health system ranks last among eleven countries on measures of access, equity, quality, efficiency, and healthy lives. The Commonwealth Fund. June 16, 2014. www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last
4. Congress of the United States, Congressional Budget Office. *Budget Options, Vol 1.: Healthcare*. December 2008:72
5. Muhlestein D, Garner P, Caughley W, de Lisle K. Projected growth of accountable care organizations. White Paper. Leavitt Partners. Dec 2015. www.leavittpartners.com.
6. Goodman JC, Wedekind LJ. How the Trump administration is reforming Medicare. Health Affairs Blog. May 3, 2019. www.healthaffairs.org/do/10.1377/hblog 20190501.529581.
7. HITC Staff. Survey: Less than 1 in 4 physicians are well prepared to meet MACRA Requirements. HIT Consultant. June 29, 2017. www.hitconsultant.net/2017/06/29/ ama-kpmg-macra-qpp/.
8. Mostashari F, Sanghavi D, McClellan M. Health reform and physician-led accountable care: the paradox of primary care physician leadership. *JAMA*. 2014;311(18):1855-56.
9. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed in April 2015 with a 92-8 Senate vote and 392-3 House of Representatives vote.
10. During the Obama administration, the Final Rule implemented by the law was published on October 14, 2106. During the Trump administration, a proposed rule to ease administrative burdens was published on June 30, 2017.
11. The Commonwealth Fund. *US Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives*. The Commonwealth Fund, June 16, 2014. www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last
12. NEJM. *Unlocking the Opportunities for Health Care Delivery Transformation. NEJM Catalyst.* May 2019. http://join.catalyst.nejm.org/download/understanding-barriers-unlocking-opportunity-ebook2019/register.

THE PATIENT-CENTERED PAYOFF:

Driving Practice Growth through Image, Culture, and Patient Experience

JUDY CAPKO & CHERYL BISERA

Making Connections Between Learning Styles and Effective Leadership

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Developing an understanding of the role learning styles plays in physician education can be an important component of leadership development.

KEY WORDS: Teaching model; learning style model; experiential learning; virtual reality; three-dimensional modeling; health literacy; patient safety; patient care.

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See one, do one, teach one has been the prevailing teaching model in medicine for decades. The model, attributed to William Halsted, the first professor of surgery at Johns Hopkins Hospital, follows the premise that the replication of good clinical practice under the supervision of medical experts will provide sufficient training for future generations of clinicians.[1] In addition, the concept of 10,000 hours of training has been considered a mandatory threshold to create an expert in a professional discipline.[1]

Changes in healthcare delivery, an increase in the global burden of disease, and the diversity of roles available to physician leaders, however, require that we reassess how tomorrow's physicians should be educated to achieve and maintain competence and evolve as leaders.[2] Here, we explore how learning style models can be effectively applied in the education and work environments to create and maintain competent physician leaders.

EXAMINING LEARNING STYLES

Individuals have different strengths and preferences in the way they process, interpret, and retrieve information, commonly known as learning style. Learning styles are characteristic cognitive, effective, and psychosocial behaviors that serve as relatively stable indicators of how learners perceive, interact with, and respond to their learning environment.[3] Simply put, learning styles are approaches or methods of learning.

The concept of learning styles, which originated in the 1970s, helps us understand that we all have preferences in the way we learn — a preferred method of processing information; thus, understanding or recognizing an individual's preferred way of learning may help him or her learn better and in less time.[4]

Learning styles are not fixed personality traits; however, individuals usually prefer one style over another. Preferences may also change over time and/or based on learning environment.[3] While each style may suggest a certain preference for a specific learning strategy, a single learning style is not all encompassing. For example, an individual may prefer to learn by doing but could also learn the same information by the passive act of reading.

The application of learning styles has been debated since their inception. Should the learning style of the student match the learning style of the teacher? Some suggest students might become disengaged if their preferred learning style is not integrated into the educational program[3] while others believe that presenting students with learning situations in which they are uncomfortable will challenge their learning and lead to a more productive educational experience.

The diversity of learning styles among students in classrooms, hospitals, or clinical sites presents challenges for physician educators because students bring various educational backgrounds, life experiences, cultures, and learning styles into healthcare — a profession that has embraced multidisciplinary teams to improve patient care. Overall, educators with an awareness of different learning styles can develop diversified teaching approaches to fit most of their students' needs. Simply knowing a student's learning style improves student learning, independent of the teaching method.[3] Understanding and addressing learning styles also provides individual students insights into their own learning strengths and weaknesses.[5]

Based on this information, students and preceptors can use learning styles to initiate discussions about learning,

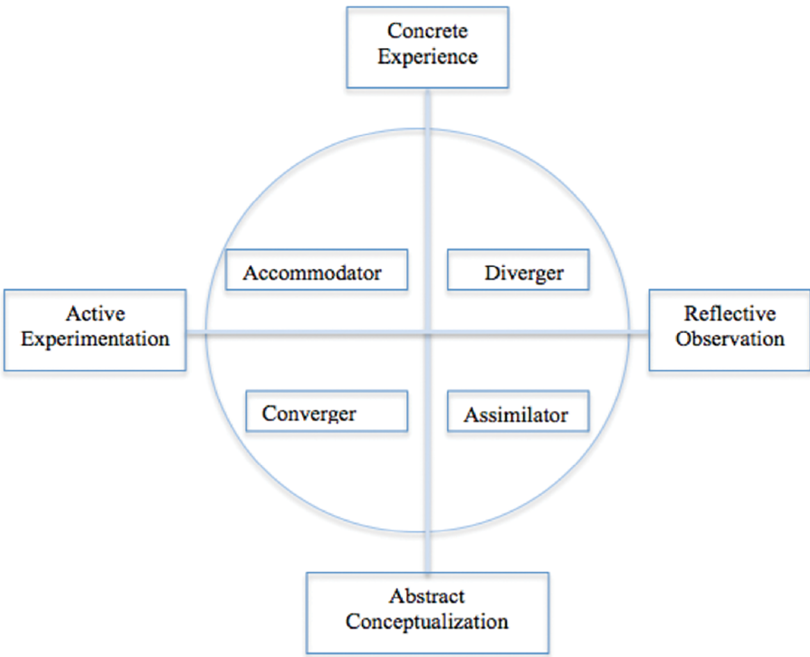

FIGURE 1. Kolb's Learning Model[33] – Modified from Manolis, *et al.* (2013)

especially during student orientation or new work assignments, and to promote self-reflection by students and preceptors about how the student likes to learn, which helps both in the professional development process.

Because physicians at every level can be described as lifelong learners, a scholarly review of learning style processes can improve their learning experiences. Examination of physician leadership effectiveness influenced by learning style awareness is warranted if we want to continue to diversify the ranks of physicians taking leadership roles in clinical, academic, and public health.

LEARNING STYLE MODELS

Several models can help educators and students better understand and leverage their learning styles.

Kolb's Experiential Learning Model

The Kolb model defines learning as "the process whereby knowledge is created through the transformation of experience."[6] In this approach, learning is viewed as a lifelong process punctuated with experiences that require adaptation throughout learning.[6] It emphasizes not only the outcome of learning, but also the process or experience of learning. This model suggests that learning should begin as an educational process with an understanding of each student's beliefs and attitudes toward learning.

Kolb's learning model describes various styles of learning in a hypothetical circular four-stage cycle beginning with a two-step process (see Figure 1):

1. How the learner gathers information:
   — *Concrete experience* (experiencing) — learning from new experiences; or
   — *Abstract conceptualization* (thinking) — learning from conceptual and analytical thinking to achieve understanding of the experience.
2. How the learner internalizes or acts on information:
   — *Active experimentation* (doing) — active trial-and-error learning; or
   — *Reflective observation* (reflecting) — considering the task and potential solutions before attempting action.

Kolb's circular model defines four learning styles: convergence, divergence, assimilation, and accommodation,[3] which can be summarized across axes (see Figure 1):

- *Converger (Abstract, Active)*: The Converger uses abstract conceptualization and active experimentation. Action is based on an abstract understanding of the task and projected strategies for successful completion of the task. Convergers prefer to work in small groups, enjoy competitive environments, and aspire to be responsible for their own learning.
- *Diverger (Concrete, Reflective)*: The Diverger combines concrete experience and reflective observation. These individuals are creative learners because they reflect on multiple strategies for learning, problem solving, and developing inventive solutions. Divergers prefer working in groups, but only when they are involved in activities without time constraints.
- *Assimilator (Abstract, Reflective)*: The Assimilator favors abstract conceptualization and reflective observation.

Concerned primarily with explanations of their observations, Assimilators prefer individual assignments and extensive feedback on their performance.

- *Accommodator (Concrete, Active)*: The Accommodator uses concrete experience and active experimentation. Accommodators have a strong preference for hands-on learning and active learning strategies and often are better able than most to adapt to diverse situations.

VARK Learning Model

Introduced by Neil Fleming in 2006,[7] the VARK learning model allows students to categorize their learning styles based on the sensory modalities involved in taking in information:[4] Visual, Auditory, Read/Write, and Kinesthetic. The theory considers that most individuals are multimodal, meaning they have a preference for more than one VARK learning style.

- *Visual*: Learners prefer information presented as graphs, pictures, and symbols — data represented with methods other than words.
- *Auditory:* Learners prefer information to be audio. They learn best from oral questions, answers, and discussion.
- *Read/Write*: Learners prefer information that is written or read: text, books, or handouts.
- *Kinesthetic*: Learners prefer hands-on learning that uses the senses of sight, taste, smell, touch.

The VARK learning style is popular in educational programs for its simplicity and intuitive sense.[8]

Felder-Soloman Model

The Felder-Soloman model was designed in 1987 to provide an approach aimed specifically at engineering instructors.[5] This model describes four contrasting student learning styles:[9]

1. *Sensing* (concrete, practical, orientated toward facts and procedures) versus *Intuitive* (abstract, innovative, orientated toward theories and underlying meanings).
2. *Visual* (visual representations of presented material) versus *Verbal* (written and spoken explanations).
3. *Sequential* (linear thinking in small incremental steps) versus *Global* (holistic thinking in large leaps).
4. *Active* (learn by doing and experimentation) versus *Reflective* (learn by thinking and reasoning).

(The Felder-Soloman interactive questionnaire can be found at https://www.webtools.ncsu.edu/learningstyles/)

Herrmann Brain Dominance Instrument®

Developed by Ned Herrmann in 1995, the Herrmann Brain Dominance Instrument is a 120-question student survey. The instrument is based on the assertion that brain dominance is natural and normal for all human beings[10] and quantifies an individual's preference for a specific "thinking" style.

The Herrmann model groups people into four categories of preferential thinking based on the task specialized function of the physical brain (see Figure 2):[9]

- *Quadrant A*: External learning (left brain, cerebral). Logical, analytical, factual, critical. Used for learning via lectures and textbooks.
- *Quadrant B*: Procedural learning (left brain, limbic). Sequential, organized, planned, detailed, structured. Learn through methodical step-by-step testing of what is being taught, with practice through repetition.
- *Quadrant C*: Interactive learning (right brain, limbic). Emotional, interpersonal, sensory, kinesthetic, symbolic. Learn by discussing and hands-on, sensory-based experiments where learners repeatedly fail but continue trying with positive verbal feedback and encouragement.
- *Quadrant D*: Internal learning (right brain, cerebral). Visual, holistic, innovative. Learn by understanding concepts.

Table 1 summarizes these learning styles, their strengths and weaknesses.

Although students with the same preferred thinking style communicate and understand each other in study groups, students who do not share those preferences will have difficulty communicating and learning in that group; therefore, being aware of learning styles may help guide the composition of small educational and study groups.

(The Herrmann Brain Dominant interactive questionnaire can be found at http://interactive.hbdi.com.)

LEARNING STYLES AND HEALTHCARE PROFESSIONALS

Healthcare professionals can use their knowledge of learning styles to the advantage of patients, colleagues, and themselves.

Physician-Patient Relationship

The overall goal of patient education is to help patients assume responsibility for their own care. A prerequisite is that physicians assess patients' knowledge, behaviors, attitudes, and skills, including their learning needs and style[11] so physicians can provide care plans in language appropriate both to the patients and to medical colleagues.

Studies show patients' self-care skills are often enhanced by the inclusion of more than one learning approach, further strengthening the notion that physicians should continually confirm their patients' preferred learning styles.[12] Although physicians may be able to use multiple tools and formats that address their patients' preferred learning styles, selection must be based on an assessment of each patient's needs, willingness, barriers, and abilities. For example, in explaining a procedure for surgical consent, the physician will know whether to use life-like models and radiographs, brochures and pamphlets, or a video

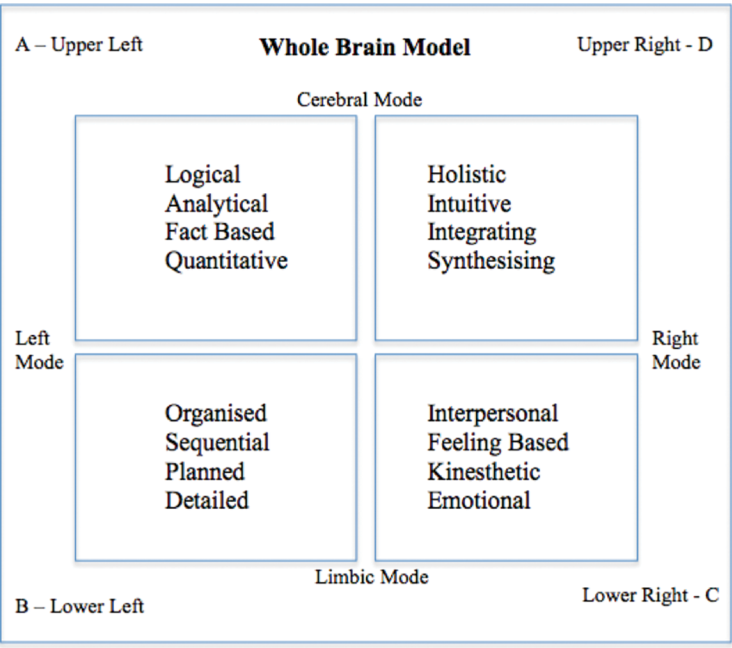

FIGURE 2. Herrmann Brain Dominance Whole Brain Thinking® Model[34]
Modified from Herrmann Solutions (2020)

TABLE 1. Summary of Strengths and Weaknesses of Four Learning Style Models

Learning Styles	Strengths	Weaknesses
Kolb	• Recognizes learning styles are not fixed personality traits but rather patterns of behavior • Can be applied to overall curriculum design • Is used for numerous studies on learning styles and career choices of medical students, physicians, and healthcare professionals	• Not suitable for individual selection • No evidence of improved academic performance
VARK	• Is easier to understand versus other learning styles • Promotes effective learning in multiple settings • Is flexible for multimodal learners as they can adapt to multimodal learning environments • Demonstrates how to manage teams more efficiently	• Difficult to accommodate all learning styles in a single learning environmental setting • Difficult for teachers to create a curriculum that encompasses every VARK modality • Does not factor in motivation or personality of learner
Felder-Soloman	• Is based on tendencies • Allows mentors to use a range of teaching techniques to improve student learning, self-confidence, and satisfaction with their instruction • Acknowledges high-performing learners with behavior tendencies can act differently on occasion • Gives students insights into their possible learning strengths and weaknesses	• Lack of success in predicting academic performance • Application of learning style dependent on designing effective instruction
Herrmann Brain Dominance	• Addresses four distinct thinking preferences (analytical, organized, strategic, interpersonal) vs. traditional left/right brain theory • Improves communication through further understanding of how others receive information • Positively encourages change and growth while considering mature values and attitudes • Addresses established habits and personality traits, while including situational preferences	• Can be considered overly simplistic for certain situations • Only applicable to older age groups • Needs additional research and academic study

to help the patient understand the procedure and its risks, benefits, and alternatives.

Health literacy, which refers to individuals' ability to understand their healthcare issues and how to properly care for themselves, is often an explanation for patients' non-compliance and non-adherence to treatment plans; they simply lack the skills necessary to comprehend them.[13]

Because many Americans have below-average literacy skills, written documents and other patient education tools should be aimed at the third- to fifth- grade reading level and routinely used in combination with other teaching strategies for reinforcement.[14] Patients who receive materials tailored to their health literacy level and learning style preference show better comprehension of their medical conditions than patients receiving materials customized for the general health literacy level.[15]

The VARK model is a simple guide for evaluating patient preferences. When physicians recognize which VARK learning style each patient prefers, they can tailor their medical explanation to the patient's learning preference. Incidentally, studies have shown that patients who play online games have increased health-related knowledge, greater self-efficacy to engage in health-related behaviors, and improved adherence to medical recommendations and regimes.[16] Games combine entertainment with multiple learning styles, all while educating patients at their own pace.

Medical Students and Physicians

As students progress through medical school, their learning experiences transition from knowledge-based learning to application of acquired knowledge to real-life contexts.[17] Most students eventually develop their own study methods, but initially they are more likely to use study strategies that have been recommended by older students than to trust in their own learning style.[5]

Knowing this, medical educators should encourage students to recognize their own learning styles and preferences in the way they absorb and process information. Felder argues that teachers and professors who are unaware of learning styles may unintentionally teach in a way that creates a disadvantage for some students called "mismatching." Alternatively, if professors try to teach exclusively in their students' preferred learning styles, the students may not make the effort to adapt to other styles and reach their potential in school and as professionals.[5]

The challenge is to "teach around the learning cycle" in an attempt to address all students' learning styles,[18] but students must understand that when they are physicians, they may elicit a negative response from their patients if they approach them using a learning style with which the patients are uncomfortable.

The most preferred VARK modality among medical students is kinesthetic followed by aural. In the Kolb learning style, the most common type of learning style among students is Converger, which describes learners who prefer to work in small groups, enjoy competition, and like to be responsible for their own learning.[3]

This information is useful as medical schools adapt the teaching approaches to their students. For example, some medical schools have replaced the traditional gross anatomy laboratory with computer-based anatomy lessons and tools. While this change appeals to some learners, it has the potential to leave those with a kinesthetic (hands-on) learning style behind.

With regard to continuous learning, once board certified, physicians must complete board recertification requirements every two years for maintenance of certification (MOC).[19] In the past, physician board recertification consisted of an in-person test every 10 years; however, with the new MOC model, physicians' multiple learning styles are taken into account as they prepare for and then complete their MOC exams biannually with regular assessments and performance improvement activities.

Physician Leaders

Critics of traditional medical education curricula question whether medical students receive ample content and experience to become effective leaders. Despite recognition that leadership skills are important to physicians, medical education curricula rarely teach leadership skills.[20] Traditional medical school curricula largely exclude content in the public health domain, the business of healthcare, or leadership.

Current and future designers of medical school curricula should recognize that medical students need and value skills beyond traditional medical education because they become de facto leaders the moment they step into the clinical context. In a recent national survey, medical residents indicated that they supported the addition of business management and leadership education to their curricula.[21] Unfortunately, the time required for accreditation in graduate medical education (GME) precludes opportunities for such training during medical school and residency.

Although the majority of the literature surrounding learning styles is embedded in education and the classroom, a medical organization's new employees also have learning needs.[22] Consequently, there are many advantages to physician leaders determining the learning styles of their employees and applying the appropriate method of training or education to suit each individual's learning styles.

Learners who are actively engaged in the training or learning process are more likely to achieve success in the task at hand. Learners engaged in their own learning process feel a sense of control, which in turn promotes higher self-esteem and motivation that will then have a positive influence on the outcomes.[23]

ACTIVE APPLICATION OF LEARNING STRATEGIES

An advanced understanding of learning styles can improve the leadership qualities of physicians, which will enhance their interaction with patients, their students, and those whom they supervise.

Although learning styles cannot be used as a predictor of success, they may promote self-awareness of the various ways individuals teach and learn a range of content. Student and educator learning styles do not have to match for the student-teacher relationship to be successful.[3] On its own, learning style awareness does not influence academic performance; therefore, the exploration of other potential strategies that integrate learning styles into curricula may help to teach and maintain competent physicians.[24]

Implementing active and self-directed learning strategies will produce a positive behavioral change in future medical professionals, resulting in an increase in competent physicians and perhaps leaders.[25]

Simulation-based training is an example of an active application of various learning strategies that provides realistic medical education in a safe, error-tolerant environment with advantages over conventional bedside training.[26] A vital educational aid that complements clinical instruction, simulation can provide future physicians and physician leaders with advanced clinical scenarios while offering structured, realistic, and safe learning environments earlier in the curriculum.[27] Poor performances during clinical simulations reveal and prevent provider errors without harming actual patients.

Simulation has surpassed traditional clinical education as a powerful educational tool that yields immediate and lasting results while reducing the training time to competence.[27] It presents an opportunity to use more rigorous, scientific methods to identify key medical competencies, including leadership. Two examples of modern simulation-based training technologies that encompass active and self-directed learning style adaptations are virtual reality and three-dimensional modeling.

Virtual Reality

Technology advancement has made information and content readily available to learners. No longer is it a question of whether a student can access or retain facts, but how to apply them to patient care.[28]

Virtual reality (VR) is emerging as an effective means to deliver instantaneous patient simulations and interactions. The growth of VR as an educational tool is transforming medical education at many levels. VR also could be used to enhance leadership education through simulated team meetings, examples of simulated coaching, or even during peer review sessions or reviews of patient safety events.

Virtual reality simulations can encompass each VARK learning modality, as the simulations are visual, auditory, display written words, and have a touch-enhanced virtual world.[28] Learners best retain information and succeed by doing, particularly when the experience is self-directed, and VR is a practical example of an active and self-directed learning strategy that can directly aid in increasing competence among physicians.[29]

Virtual reality offers experiential learning as clinical scenarios are discussed in the classroom then immediately simulated in real time. If the physician makes an error during a simulation, the software provides instantaneous feedback and the physician can repeat the scenario until competence is assured.

VR provides opportunities to learn from clinical encounters without jeopardizing real-life patients. Having physicians apply their knowledge to simulated clinical practice while simultaneously learning from their mistakes improves clinical competency and patient safety.

Three-Dimensional Modeling

With restrictions on work hours and the supervision requirements for trainees, mastering procedures efficiently can be difficult.[30]

Three-dimensional modeling (3-D modeling) in medical education is the creation of an anatomically accurate replication of patient-specific models. These replicable models allow for improved hands-on learning for students, proceduralists, or surgeons. Similar to VR simulations, 3-D modeling allows students to learn and hone their skills without practicing on real patients. Additionally, 3-D models have proven to improve learning, performance, and the confidence of the trainees regardless of their area of expertise.[29]

SUMMARY

The dual leadership responsibility of addressing the public's expectations for patient safety and assuring adequate education for physicians across their life cycle from student through physician leader increases the need for further research into learning styles and their role in physician education.

Current research shows little evidence that an advanced understanding of learning styles positively impacts educational outcomes; however, modern technology has changed the medical education process.[31] Today's physician will need additional assistance navigating the rapidly changing medical environment while efficiently integrating the plethora of content that is available.

It is inevitable that future physicians will be required to rapidly integrate formal knowledge and clinical experience, familiarity in patient-centered, a comprehension of healthcare systems management, educational principles,

and leadership.[32] Learning style preferences should continue to be researched at the medical student and educator level, with initial discussions covering the various styles of learning. This can begin with a discussion of learning style preferences during student orientations or healthcare training programs and evolve to include patient-centered approaches and leadership.

As medicine advances, it is essential that physicians embrace lifelong learning early in their careers and understand how to integrate both content and methods of learning. Computer technologies hold promise in providing medical professionals access to medical knowledge and case scenarios faster and more efficiently, while embracing multiple learning styles instantaneously; however, other innovative teaching approaches will also likely be developed to augment the repertoire of modalities available to physicians in the future.

REFERENCES

1. Loganath K, Adamson PD, Moss AJ. See One, Do One, Teach One: Finding Your Mentor in Academic Medicine. *Future Science OA*. 2019;*5*(4):FSO385.
2. Armstrong E, Parsa-Parsi R. How Can Physicians' Learning Styles Drive Educational Planning? *Acad Med*. 2005;80(7):680–84.
3. Robles J, Cox CD, Seifert CF. The Impact of Preceptor and Student Learning Styles on Experiential Performance Measures. *Am J Pharm Educ*. 2012; 76(7):128.
4. SK S, Helena TC. VAK Styles of Learning Based on the Research of Fernald, Keller, Orton, Gillingham, Stillman, Montessori and Neil D Fleming. *International Journal for Innovative Research in Multidisciplinary Field.* 2017; 3(4):2455–620.
5. Felder R, Spurlin JE. Applications, Reliability and Validity of the Index of Learning Styles. *International Journal of Engineering Education*. 2005; (21):103–12.
6. Colucciello ML. Learning styles and instructional processes for home healthcare providers. *Home Healthc Nurs*. 1993;*11*(2):43–50.
7. Saga Z, Qamar K, Trali G. Learning Styles-Understanding for Learning Strategies. *Pak Armed Forces Med*. 2015; 65(5):706–709.
8. Fleming N, Bonwell C. How Do I Learn Best? A Learner's Guide to Improved Learning. 2019; https://vark-learn.com/wp-content/uploads/2019/07/How-Do-I-Learn-Best-Sample.pdf. Accessed February 7, 2020.
9. Felder RM. Matters of Style. *ASEE prism*. 1996;6(4):18–23.
10. Boer DM, Berg VD. The Value of the Herrmann Brain Dominance Instrument (HBDI) in Facilitating Effective Teaching and Learning of Criminology. *Acta Criminologica*. 2001:14(1):119–29.
11. Marcus C. Strategies for Improving the Quality of Verbal Patient and Family Education: A Review of the Literature and Creation of the Educate Model. *Health Psychol Behv Med*. 2014;2(1):482–95.
12. Bokhari N, Mubashir Z. Learning Styles and Approaches Among Medical Education Participants. *Educ Health Promot.* 2019;30(8):1–5.
13. Miller TA. Health Literacy and Adherence to Medical Treatment in Chronic and Acute Illness: A Meta-Analysis. *Patient Educ Couns*. 2016;99(7):1079–86.
14. Sudore RL, Schillinger D. Interventions to Improve Care for Patients with Limited Health Literacy. *J Clin Outcomes Manag.* 2009; 16(1):20–29.
15. McCray AT. Promoting Health Literacy. *J Am Med Inform Assoc.* 2005;12(2):152–63.
16. Primack BA, Carroll MV, McNamara, M, *et al.* Role of Video Games in Improving Health-Related Outcomes: A Systematic Review. *Am J Prev Med*. 2012;42(6):630–38.
17. Roberts V, Perryman M, Rivers PA. A Discussion Paper on the Assessment of Student Learning Outcomes for Healthcare Management. *Health Education Journal*. 2009;68(2): 140–48.
18. Felder RM. Reaching the Second Tier: Learning and Teaching Styles in College Science Education. *J. College Science Teaching.*1993;23(5): 286–90.
19. Kaplan DA. Physicians' Battle to Limit Maintenance of Certification Requirements Continues Despite Testing Changes. *Medical Economics.* 2018;95(19).
20. Bokhari NM, Mubashir Z. Learning Styles and Approaches Among Medical Education Participants. *J Educ Health Promot.* 2019;8:1–5.
21. Gnanavel S. Leadership and Management Skills for Psychiatry Trainees: An Integral Part of Curriculum? *Asian Journal of Psychiatry*. 2016;19:24–25.
22. Hardy GE, West MA, Hill F. Components and Predictors of Patient Satisfaction. *British Journal of Health Psychology*. 1996;1(1):65–85.
23. Pritchard, Alan. Ways of Learning. *Journal of Educational Technology*. 2014;46(6): E34–E35.
24. Rashid A, Shah HA, Allaf M. Medical Student Learning Styles: Does It Really Matter? *Adv Med Educ Pract.* 2019;10:513–14.
25. Armstrong E, Parsa-Parsi R. How Can Physicians' Learning Styles Drive Educational Planning? *Acad Med*. 2005;80(7):680–84.
26. Murphy JG, Cremonini F, Kane GC, Dunn W. Is Simulation Based Medicine Training the Future of Clinical Medicine? *Eur Rev Med Pharmacol Sci.* 2007;11(1):1–8.
27. Pottle J. Virtual Reality and the Transformation of Medical Education. *Future Healthc J*. 2019;6(3):181–85.
28. Gorman PJ, Meier AH, Rawn C, Krummel TM. The Future of Medical Education Is No Longer Blood and Guts, It Is Bits and Bytes. *Am J Surg*. 2000;180(5):353–56.
29. Garcia J, Yang Z, Mongrain R, Leask RL, Lachapelle K. 3D Printing Materials and Their Use in Medical Education: A Review of Current Technology and Trends for the Future. *BMJ Simulation and Technology Enhanced Learning*. 2018;4(1):27–40.
30. Shakir HJ, Shallwani H, Levy EI. See One, Do One, Teach One?: Paradigm Shift with Three-Dimensional Printing. *Neurosurgery*. 2017;80(1):3–5.
31. Guze PA. Using Technology to Meet the Challenges of Medical Education. *Trans Am Clin Climatol Assoc*. 2015;126:260–70.
32. Robinson JL. Connecting Leadership and Learning: Do Versatile Learners Make Connective Leaders? *Higher Learning Research Communications*. 2016;6(1):n1.
33. Manolis C, Burns DJ, Assudani R, Chinta R. Assessing Experiential Learning Styles: A Methodological Reconstruction and Validation of the Kolb Learning Style Inventory. *Learning and Individual Differences*. 2013;23:44_52.
34. Herrmann N. The Theory Behind the HBDI and Whole Brain Technology. *Better Results Through Better Thinking*; Herrmann Solutions website. https://think.herrmannsolutions.com/hubfs/Articles/Theory_Behind_The_HBDI___and_Whole_Brain___Technology.pdf. Accessed February 7, 2020.

KOLB LEARNING STYLE QUESTIONNAIRE[33]

If you agree more than you disagree with a statement, mark the box to the left of the question. If you disagree more than you agree, leave the box blank. If you find yourself wondering which situation to think of when answering a question, just think about how you are when you are working with people. Go with your first gut reaction instead of overthinking your response.

- ❏ I have strong beliefs about what is right and wrong, good and bad.
- ❏ I often act without considering the possible consequences.
- ❏ I tend to solve problems using a step-by-step approach.
- ❏ I believe that formal procedures and policies restrict people.
- ❏ I have a reputation for saying what I think, simply and directly.
- ❏ I often find that actions based on feelings are as sound as those based on careful thought and analysis.
- ❏ I like the sort of work where I have time for thorough preparation and implementation.
- ❏ I regularly question people about their basic assumptions.
- ❏ What matters most is whether something works in practice.
- ❏ I actively seek out new experiences.
- ❏ When I hear about a new idea or approach, I immediately start working out how to apply it in practice.
- ❏ I am keen on self-discipline such as watching my diet, taking regular exercise, sticking to a fixed routine, etc.
- ❏ I take pride in doing a thorough job.
- ❏ I get on best with logical, analytical people and less well with spontaneous, 'irrational' people.
- ❏ I take care over how I interpret data and avoid jumping to conclusions.
- ❏ I like to reach a decision carefully after weighing up many alternatives.
- ❏ I am attracted more to novel, unusual ideas than to practical ones.
- ❏ I don't like disorganized things and prefer to fit things into a coherent pattern.
- ❏ I accept and stick to laid down procedures and policies so long as I regard them as an efficient way of getting the job done.
- ❏ I like to relate my actions to a general principle, standard or belief.
- ❏ In discussions, I like to get straight to the point.
- ❏ I tend to have distant, rather formal relationships with people at work.
- ❏ I thrive on the challenge of tackling something new and different.
- ❏ I enjoy fun-loving spontaneous people.
- ❏ I pay careful attention to detail before coming to a conclusion.
- ❏ I find it difficult to produce ideas on impulse.
- ❏ I believe in coming to the point immediately.
- ❏ I am careful not to jump to conclusions too quickly.
- ❏ I prefer to have as many sources of information as possible – the more information to think over the better.
- ❏ Flippant, superficial people who don't take things seriously enough usually irritate me.
- ❏ I listen to other people's points of view before putting my own view forward.
- ❏ I tend to be open about how I'm feeling.
- ❏ In discussions, I enjoy watching the plotting and scheming of the other participants.
- ❏ I prefer to respond to events in a spontaneous, flexible way rather than plan things out in advance.
- ❏ I tend to be attracted to techniques such as flow charts, contingency plans etc.
- ❏ It worries me if I have to rush work to meet a tight deadline.
- ❏ I tend to judge people's ideas on their practical merits.
- ❏ Quiet, thoughtful people tend to make me feel uneasy.
- ❏ I often get irritated by people who want to rush things.
- ❏ It is more important to enjoy the present moment than to think about he past or future.
- ❏ I think that decisions based on a careful analysis of all the information are better than those based on intuition.
- ❏ I tend to be a perfectionist.
- ❏ In discussions, I usually produce lots of spontaneous ideas.
- ❏ In meetings, I put forward practical, realistic ideas.
- ❏ More often than not, rules are there to be broken.
- ❏ I prefer to stand back from a situation and consider all the perspectives.
- ❏ I can often see inconsistencies and weaknesses in other people's arguments.
- ❏ On balance I talk more than I listen.
- ❏ I can often see better, more practical ways to get things done.
- ❏ I think written reports should be short and to the point.
- ❏ I believe that rational, logical thinking should win the day.
- ❏ I tend to discuss specific things with people rather than engaging in social discussion.
- ❏ I like people who approach things realistically rather than theoretically.
- ❏ In discussions, I get impatient with irrelevant issues and digressions.
- ❏ If I have a report to write, I tend to produce lots of drafts before settling on the final version.
- ❏ I am keen to try things out to see if they work in practice.
- ❏ I am keen to reach answers via a logical approach.
- ❏ I enjoy being the one that talks a lot.

- ❏ In discussions, I often find I am a realist, keeping people to the point and avoiding wild speculations.
- ❏ I like to ponder many alternatives before making up my mind.
- ❏ In discussions with people I often find I am the most dispassionate and objective.
- ❏ In discussions I'm more likely to adopt a 'low profile' than to take the lead and do most of the talking.
- ❏ I like to be able to relate current actions to the longer-term bigger picture.
- ❏ When things go wrong, I am happy to shrug it off and 'put it down to experience'.
- ❏ I tend to reject wild, spontaneous ideas as being impractical.
- ❏ It's best to think carefully before taking action.
- ❏ On balance, I do the listening rather than the talking.
- ❏ I tend to be tough on people who find it difficult to adopt a logical approach.
- ❏ Most times I believe the end justifies the means.
- ❏ I don't mind hurting people's feelings so long as the job gets done.
- ❏ I find the formality of having specific objectives and plans stifling.
- ❏ I'm usually one of the people who puts life into a party.
- ❏ I do whatever is practical to get the job done.
- ❏ I quickly get bored with methodical, detailed work.
- ❏ I am keen on exploring the basic assumptions, principles and theories underpinning things and events.
- ❏ I'm always interested to find out what people think.
- ❏ I like meetings to be run on methodical lines, sticking to laid down agenda.
- ❏ I steer clear of subjective (biased) or ambiguous (unclear) topics.
- ❏ I enjoy the drama and excitement of a crisis situation.
- ❏ People often find me insensitive to their feelings.

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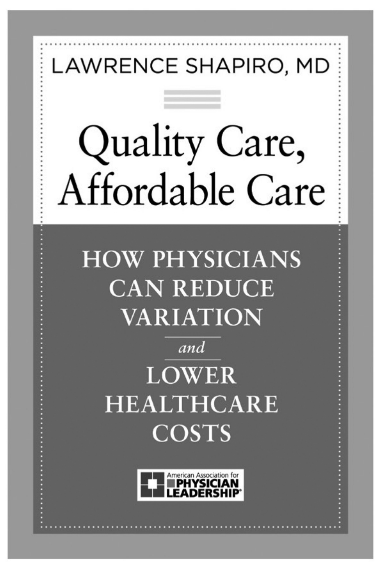

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Doctor Get Your A.C.T. Together

Neil Baum, MD*

Changes in healthcare are occurring rapidly. The old paradigm of recording the doctor–patient encounter on paper records, being paid for our services on a fee-for-service basis, and having patients routinely wait 30 to 60 minutes in the reception area before they are even placed in an exam room are over and will soon be replaced by a new approach to healthcare. Welcome to the new world, where patients ask about the cost of visits and procedures, where it is necessary to obtain prior authorization before the doctor can treat the patient, where high copays and deductibles are routine, where precision medicine and gene therapy are becoming common, and where we will soon see the use of artificial intelligence to diagnose and treat medical problems. All of these changes will alter the doctor–patient relationship. Doctors who are able to be flexible, who can adapt to new methods of patient care, and who are amenable to shifting gears are the ones who will survive in this new healthcare environment. This article discusses three elements—access to care, compassion, and transparency—that will result in significant changes in the near future and will allow medical care to continue even with the transformations taking place.

KEY WORDS: **Access; compassion; transparency; patient satisfaction; online reputation management; artificial intelligence; patient scheduling.**

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Attention to access to care, compassion, and transparency (A.C.T.) will result in significant changes in medical practice in the near future and will allow us to continue providing quality medical care to our patients even with the many, rapid transformations taking place.

ACCESS TO HEALTHCARE

Access to healthcare means that a person can see the right medical doctor at the right time and in the right place for a fee paid by payers or a reasonable fee paid by the patient. Patient access to healthcare sets the baseline for all patient encounters with the healthcare industry. When a patient cannot access his or her clinician, it is impossible for that patient to receive medical care, and both patient outcomes and patient satisfaction scores will plummet. Lack of adequate access is a potential healthcare crisis for millions of people in the United States.

Easy and seamless access to the doctor and the practice builds patients' relationships with providers and is likely to achieve improved patient outcomes. There is an impending physician shortage, which means the situation of access to medical care will only become worse. Patients may face availability issues as older physicians retire at an early age, potentially shrinking the workforce. Provider dissatisfaction also is contributing to this shrinkage of the workforce. In a survey from the Physicians Foundation, 53% of providers reported low job satisfaction and 62% expressed a negative view of the future of the medical profession.[1]

Other solutions to the impending physician shortage include adding to the clinical workforce by expanding the number of available graduate medical education residency slots, expanding medical school loan-forgiveness programs, and removing barriers to immigration so that skilled, foreign-trained physicians are able to practice in the United States.

Access to healthcare involves two major and several minor components. The first and most frequently discussed is the patient's ability to pay. The second is the availability of healthcare personnel and facilities close to where people live. Other issues to be considered are that the practice must be accessible by transportation, should be culturally acceptable to the patients, and must be capable of providing appropriate care in a timely manner and in a language spoken by those who need assistance.

Telemedicine

Healthcare organizations have been using telemedicine to close care gaps caused by the long distances that many patients must travel to have access to in-person healthcare. Direct-to-consumer telemedicine allows patients to use their own computers or smartphones to conduct a video call with a provider. Many smaller facilities in rural areas also use telemedicine to connect with experts in urban areas. Telemedicine has the potential to keep patients from having to travel great distances to receive intensive or specialized care.

Telemedicine is not only for patients in rural areas. It can help expand access to care for two groups of patients: those in rural areas who live far away from a clinic or hospital; and those who have full schedules and may not be able to see a doctor during the practice's normal office hours.

Telemedicine also is changing how schools deliver healthcare services for both students and staff. Today's school districts do not have the funding to put a nurse in every school, and those nurses who do work in schools often are overwhelmed by a variety of issues, from complex emotional and behavioral health cases to children with one or more chronic conditions. School-based telemedicine uses telecommunications, including interactive video conferencing and store-and-forward transmissions, to deliver a variety of healthcare services to students attending that school. The current model of caring for schoolchildren often results in a disruption in learning—a child must be picked up by a parent or caregiver and then spend a half a day or more at the doctor's office, missing classroom learning.[2]

Telemedicine and remote patient monitoring will become an essential, cost-effective, and reliable means to expand capacity in a healthcare system marked by significant and persistent specialty shortages and geographic disparities between patients and providers. Diagnostic codes and a payment model must be developed for teleconferencing and telemedicine.

Access to care will improve if there is an improvement in the efficiency of the practice. There is a necessity to reduce government and insurance industry compliance and decrease the time- consuming regulatory burdens, such as prior authorization, that detract from patient care and increase costs.

Scheduling

Several simple fixes can improve access to providers. Practices that can extend their office hours or stagger appointments in such a way that patients can access their clinicians at convenient times provide greater patient access. Offices that conduct appointments only during traditional work hours (i.e., 9 AM to 5 PM) may not be accessible for those who must be at work during those times. Children who are in school may be unable to see pediatricians who are available only during school hours. Many healthcare organizations offer patients a typical set of office hours for patient visits, but for the working adult or parent, a clinic that is open between 8 AM and 6 PM is not always useful. Patients need convenient office hours that allow them to visit the doctor without interrupting their work or school schedules. An easy solution that can be accomplished with existing staff and no requirement for additional technology is to increase office hours. Access will improve if practices can start at 7 AM or also have early evening and weekend hours.

Making sure patients can make appointments with the right doctor, which can help improve their access to healthcare, ultimately drives more patients to the practice or to the hospital.

Access can be enhanced by improving the scheduling process. When patients do need to access in-person care, they often face find that it is difficult to schedule an appointment. When they contact a provider's call center or front desk to make an appointment, patients may encounter busy signals, may be placed on hold for a prolonged time, may have to struggle with technological issues such as being disconnected or finding their way through a phone tree, or may have trouble finding a time that meets both the patient's and the physician's schedule.[6]

Hospitals and medical practices can consider online appointment scheduling software, which allows patients to view and select appointments with their preferred providers. Online appointment scheduling improves convenience for patients and also allows them to see the right kind of doctor for their medical problems. For example, when a patient with a knee injury books an appointment, he can make sure he sees an orthopedist who specializes in knees rather than one who specializes in shoulders.

Making sure patients can make appointments with the right doctor, which can help improve their access to healthcare, ultimately drives more patients to the practice or to the hospital.

Transportation

About 3.5 million patients go without care because they cannot access transportation to their providers. Transportation is a critical social determinant of health that has recently gained nationwide attention.[3] According to an article published in the *Journal of the American Medical Association*, ridesharing services such as Lyft and Uber can improve that healthcare disparity and cut down on the $2.7 million the federal government spends each year on nonemergency medical transportation services.[4]

Uber and Lyft have plans to improve access to care arising from medical transportation issues. Both companies will help providers and patients connect with rides to medical appointments.[5]

COMPASSION

Doctors continue to be challenged to demonstrate compassion for their patients. This is very difficult to do in a 10- to 15-minute appointment accompanied by the requirement to enter data into the EHR. Multiple studies have documented that it is not unusual for a doctor to interrupt a patient only 11 seconds after the doctor initiates the discussion in the examination room.[7]

The healthcare industry, particularly physicians, is getting a bad rap about providing care and compassion compared to doctors of the past. Patients would like to return the days of TV doctors Marcus Welby, MD, or Dr. Kildare, who were quintessential examples of compassion. Today's physician depends on technology, medications, surgeries, CT scans, radiation therapies, biopsies, and blood tests, and that compassion—the "touchy-feely" part of medicine—appears to have become an afterthought. It is not rare to hear from patients that they had a medical appointment and that the doctor did not touch them or even perform a physical exam.

The Medicinal Value of Tactful Touching

From the time of Hippocrates, tactful touching has been a part of the healer's armamentarium. The Bible, both Old and New Testaments, contains numerous stories about the healing powers of tactful touching. Harry Harlow, a professor at the University of Wisconsin, performed a famous experiment that showed that primates deprived of touch did not grow and develop normally. It was Professor Harlow's opinion that essential needs like food, water, and shelter are not enough for survival. Primates, humans included, need to touch and be touched in order to survive and thrive.[8]

Touching provides a vital and necessary role in sustaining life.

Another study conducted in English orphanages during World War II showed that even if infants received adequate food, they failed to thrive unless they were held and cuddled on a frequent basis. Touching does not provide calories; however, it provides a vital and necessary role in sustaining life. Neonatal mortality decreased and growth and development improved when laywomen were brought in to hold and to cuddle the babies for several hours a day.[9]

The number of Americans seeking alternative healthcare providers has been increasing for several years.[10] Patients are seeking healthcare from complementary providers such as chiropractors, acupuncturists, massage therapists, and physical therapists. These complementary providers make ample use of touching in their approach to patients.

Doctors no longer seem to touch their patients during most office visits. It is much easier to order a CT scan or an MRI than to touch or physically examine the patient. All of us remember those amazing physicians in medical school who were able to make a correct diagnosis based on the physical exam alone and were not dependent on technology and imaging. Most physicians have forgotten how to use those physical examination skills.

Another concern is that doctors are under pressure to see more patients and as a result, there is less time to tactfully touch our patients. Tactful touching creates a positive connection between doctor and patient. Sensitivity training coaches may warn against touching our patients, but I know the medicinal value of touching and will continue to use tactful, appropriate touching.

Compassion Is Good Medicine

There is scientific evidence that compassion is good medicine. Trzeciak and Mazzarelli[11] provide overwhelming evidence for the healing power of compassion in their book *Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference.*

Kindness brings longer, healthier lives—not only for patients, the book argues, but also for healthcare professionals. When a physician is compassionate, patients heal better and more quickly, and the doctors are happier and less subject to burnout.

Studies have shown that warm, supportive interactions with patients from either doctors or nurses right before the patient goes in for surgery result in patients being calmer at the start of surgery and a decrease in the need for opiate medication following surgery. Patients also spent less time in the hospital.[12]

Technology

With the advent of artificial intelligence, we soon may not be required to take a history of the present illness, record the past medical history, or perform the review of systems. With a few clicks and within a few seconds a diagnosis with a rank of probabilities will appear on our computer screen and will recommend what studies to be ordered and what treatment might be appropriate.

Many of us fear the phrase, "The algorithm will see you now!" Medical algorithms, however, are a valuable but currently underutilized resource in healthcare. Their use at the point of care can significantly improve the quality and cost-effectiveness of medical care.

Just as airplane pilots use checklists to safeguard against mistakes and rely on formulas to plot the right speed and trajectory to take off and to get the plane safely to its

destination, medical providers can also use algorithms and checklists as a guide. Medical errors are believed to be responsible for more than 100,000 deaths a year.[13] The use of algorithms may well help lower this number and may guide a doctor quickly to the diagnosis. However, an algorithm never will be able to provide compassion, caring, and empathy. If we take the time to talk to our patients, to be good listeners, and to look at patients instead of computers, there will always be a need for doctors.

TRANSPARENCY

No one would consider staying at a hotel, buying an airline ticket, or buying an automobile without knowing the price of the service or product. Guess what? Patients also want to know the cost of their medical care before they visit the doctor or have the study or the procedure. We are in an era of rising copays, rising deductibles, and more patients having greater financial responsibility for their medical care.

There is a negative impact from not having cost transparency. According to a report from InstaMed, 74% of providers saw an increase in financial responsibility in 2015. High out-of-pocket costs can be prohibitive, causing some patients to skip recommended care.[14]

According to a poll of over 1500 patients, 25% are avoiding medical care due to its high cost.[15]

Another issue regarding price and transparency is patients' lack of understanding and confidence in the bills they receive from hospitals and medical practices. A review of patients' confidence in the accuracy of their medical bills demonstrated that just 33% of consumers felt very confident that bills from their hospital or provider are accurate. That feeling seems to have some validity: 47% of respondents also reported a billing or payment issue during their most recent healthcare experience. Such mistakes are among the ways a hospital or health system could jeopardize patient loyalty. In fact, 42% of patients say incorrect or confusing bills would cause them to seek care from a different provider.[16]

The goal of pricing transparency is that, as people have higher deductible plans, they must have the ability to select the best doctor or facility at the best price.

When, for example, patients are given the option to select an MRI provider based on cost, they select a more cost-effective option and reduce the cost by an average of $220 per person. There is proof and evidence that you can lower costs by having people use pricing transparency tools.[17]

Finally, as part of the discussion on transparency, offer your patients various ways to pay their portion of the charges. This means not only accepting, cash, checks, credit cards, and PayPal, either in person or online, but also being able to offer reasonable payment plans. Your staff should understand the practice's financial policy and apply it consistently to all patients who ask to establish a payment plan. That means being prepared to set up automatic monthly payments for large balances before they become a collection issue.

Bottom Line: The contemporary physician is going to have to adapt and change, which will probably mean learning to embrace technology. But that doesn't mean we have to forget the basics and why we became doctors in the first place. As long as we focus on the patient and provide access to care, remain compassionate, and have price transparency, we will be successful, have happy patients and a happy staff, and just may be home for dinner!

REFERENCES

1. Heath S. Patient engagement. Could low provider morale affect patient healthcare access? PatinetEngagement.com. https://patientengagementhit.com/news/could-low-provider-morale-affect-patient-healthcare-access.
2. Factors behind the adoption of school-based telehealth. mHealth Intelligence. November 21, 2016. https://mhealthintelligence.com/features/factors-behind-the-adoption-of-school-based-telehealth.
3. Health Research & Educational Trust. Social Determinants of Health Series: Transportation and the Role of Hospitals. American Hospital Association. www.aha.org/transportation.
4. Powers WP, Rinefort S, Sachin H. Nonemergency medical transportation—delivering care in the era of Lyft and Uber. *JAMA*. 2016; 316:921-922.
5. Recapping HIMSS 18 patient engagement technology news. Patient Engagement HIT. https://patientengagementhit.com/news/recapping-himss18-patient-engagement-technology-breakthroughs.
6. Heath S. Effective patient engagement strategies using health IT. EHR Intelligence. https://ehrintelligence.com/news/effective-patient-engagement-strategies-using-health-it.
7. Singh ON, Phillips KA, Rodriguez-Gutierrez R. Eliciting the patient's agenda—secondary analysis of recorded clinical encounters. *J Gen Intern Med*. 2019;34:36-40.
8. Tavris CA. Teaching contentious classics. Association for Psychological Science. September 30, 2014. www.psychologicalscience.org/observer/teaching-contentious-classics.
9. de Roiste A, Bushnell IWR. Tactile stimulation: short and long-term benefits for preterm infants. *British Journal of Developmental Psychology*. 1996;41:41-53.
10. Tindle HA, Davis RB, Phillips RS, Eisenberg DM. Trends in use of complementary and alternative medicine by US adults: 1997-2002. *Alternative Therapies in Health and Medicine*. 2005;11(1):42.
11. Trzeciak S, Mazzarelli A. *Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference*. Pensacola, FL: Studer Group; 2019.
12. Egbert LD, Battit G, Turndorf H, Beecher HK. The value of the preoperative visit by an anesthetist. A study of doctor-patient rapport. *JAMA*. 1963;185:553-555.
13. Abbasi J. Headline-grabbing study brings attention back to medical errors. *JAMA*. 2016;316:698-700.
14. LaPointe J. Providers see increased patient financial responsibility. Revcycle Intelligence. https://revcycleintelligence.com/news/74-of-providers-see-increased-patient-financial-responsibility.
15. Heath S. Healthcare costs dampen patient engagement despite satisfaction. Patient Engagement. May 19, 2016. https://patientengagementhit.com/news/healthcare-costs-dampen-patient-engagement-despite-satisfaction.
16. Pecci AW. Want to drive patients away? Stick with outdated billing practices. *Health Leaders*. November 14, 2019.
17. Gruessner V. Cost transparency, "consumer-driven healthcare" impacts payers. Healthpayer Intelligence. February 4, 2016. https://healthpayerintelligence.com/news/cost-transparency-consumer-driven-healthcare-impacts-payers.

Enhancing Culture and Employee Engagement Through Personal Accountability

Kathryn Stewart, MA, PHR*

Improving work culture and increasing employee engagement are topics at the top of the list for every business and HR leader. Encouraging personal accountability among your employees will naturally both improve work culture and increase engagement. This article defines accountability for an employee, describes what it looks like in the workplace, and gives practical tips on how to foster an environment of accountability.

KEY WORDS: **Company culture; organizational culture; employee engagement; personal accountability; fostering accountability in the workplace; workplace accountability.**

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Creating an exceptional work culture and increasing employee engagement continue to rank at the top of every business and HR leader's workplace goals. Both of these topics have received increasing attention over the past few years. I want to challenge these leaders to consider personal accountability and its relationship to and impact on culture and engagement. When leaders foster an environment of personal accountability, culture and engagement naturally improve.

WHAT IS ACCOUNTABILITY?

Sometimes the terms *accountability* and *responsibility* are used interchangeably; in fact, however, they are quite different things in the workplace. *Responsibility* is stepping up to take ownership of an activity. An employee who completes all assigned tasks for their position is taking responsibility for their job. *Accountability,* on the other hand, is stepping up to take ownership of results. The accountable employee will do what it takes to get the job done with the best results possible.

An employee who clearly understands his or her goals and does what it takes to get the desired outcome displays accountability. Don't confuse this with the employee who is seemingly always in the office. It is possible for an employee who has no personal accountability to work many hours just because he or she is inefficient. Likewise, it doesn't mean an employee who leaves right at the end of a shift to accommodate childcare or family life isn't personally accountable. That employee may be working extra hours in the evening or on the weekends. Perhaps the employee has managed to accomplish desired results within his or her work hours. It's less about the time spent on the task or project and all about the results the employee generates. The employee will do whatever it takes to ensure the completion of every one of his or her responsibilities.

> ***Employees with personal accountability understand they are working with others toward a common goal for the organization.***

Accountable employees not only are completing the responsibilities, but they also are completing them to a specific level of satisfaction. They are not just checking items off a to-do list. Determine that level of satisfaction in advance and ensure it is clearly understood. Every employee needs to know the expectations of their manager, the organization, and, most importantly, the patients or clients. Then, everything they do should meet these expectations, even if that means it takes them more time to do something.

Finally, employees with personal accountability understand they are working with others toward a common goal for the organization. They know the mission, vision, and current initiatives of the organization and how their role contributes to them. If employees do not understand the organization's mission, vision, and values, then they are working blind and have no sense of direction. Ensuring that

employees not only have a clear direction but also buy into the goals of the organization brings a sense of belonging and purpose to everyone. It also helps employees identify whom to partner with to achieve these goals.

WHY SHOULD LEADERS STRIVE TO INCREASE PERSONAL ACCOUNTABILITY AT WORK?

Yes, better work culture and increased employee satisfaction will come from an organization filled with accountable employees—but how and why?

More Trust With Reliability

When you work with people who do what they say they are going to do, you know you can rely on and trust them. When there is trust in the workplace, it eliminates the stress of the unknown. "Will they do what they said they were going to do?" or "Can I count on them?" goes away. Instead, employees will focus on their own roles and responsibilities. Suddenly, there is no need to micromanage projects.

Increased Skills and Confidence

Because accountable employees consider the best way to get the job done, they are challenged to think creatively to improve processes and efficiencies. The use of critical thinking skills enhances the employee's skill set and confidence as they witness the impact they have on the organization.

Sense of Purpose

Everyone wants to know their work is important and makes a difference to the organization. The accountable work environment is sure to demonstrate each role's impact on the organization. Employees will work together and share accountability to contribute to the organization reaching its goals. It becomes a cycle of success for individuals and the organization.

HOW CAN LEADERS FOSTER AN ENVIRONMENT OF PERSONAL ACCOUNTABILITY?

Leaders must be transparent about their expectations for personal accountability and ensure that every employee understands what that means and how that looks. Encourage employees to "see it, own it, solve it, and do it." The following sections offer some tips and ways to get started.

Acknowledge how you affect the culture.

Stop and take an inventory of your own actions and consider how they are affecting the organization's culture. Ask your employees for and be open to feedback, both positive and constructive. Really listen! Leaders must model how to give and get good feedback. Regularly requesting feedback and accepting it with gratitude is critical to developing personal accountability. Feedback truly is a gift. Once you receive it, acknowledge how you've contributed to any problems. This arms you with the power to overcome any challenges. Giving and receiving feedback does not come naturally to most people, especially new managers. By having your direct reports practice giving you feedback, you are not only learning from their input, but you are helping them develop their skills.

Define how each role affects your organization.

Many jobs require some degree of menial, repetitive work, but the key to not succumbing to the monotony of these tasks is to understand the bigger picture. If employees truly understand how their role, in conjunction with other positions, brings the mission of the company to life, they'll be much more inclined to give 100% to their jobs (even when they're not particularly passionate about the task at hand). When leaders give their employees purpose, higher engagement and satisfaction follow naturally.

One way to accomplish this is to clearly define the organization's initiatives and form goals for each role that contribute to those initiatives or the mission of the business. Continually reviewing the employee's progress toward these goals brings the focus back to the aspects of their role that contribute to the bigger picture.

Hire accountable people.

When hiring new employees, ensure they possess personal accountability or the potential for it. Past behavior is always the best predictor of future behavior, so ask plenty of questions that draw out past situations. Consider ways the candidate can show their accountability, including their ability to keep promises, consider consequences, take responsibility for mistakes, and make amends for mistakes.

Some questions you might consider asking during the interview process include the following:

- Describe a situation in which you took responsibility for a mistake you made. What were the consequences of doing so?
- Have you ever taken responsibility for a mistake that a member of your team made?
- Tell me about a time when you failed. How did you handle it?
- Tell me about a time when you chose to honor a commitment or do the right thing even though this action caused you personal hardship or wasn't the easiest way.

Provide mentors.

Although a formal mentorship program is a great perk, there are several informal ways you can foster mentor

relationships in the workplace. Ask employees who have been there longer to coach new hires. This is an excellent way for new hires to gain insight and understanding into the inner workings of your organization. It also allows for the new employees to ask questions about processes and suggest other efficiencies not previously considered. In addition to training for new job tasks, you can ask the mentors to share the history of the organization, current initiatives, and how their role contributes to those initiatives.

Consider partnering older employees with younger ones or employees with more industry background with those newer to the field. New employees are not the only ones who benefit from a mentor relationship.

Get managers in the mindset to help.

Help your managers change their thinking from holding others accountable to nurturing an environment where people are taking greater accountability. This helps foster a culture where employees proactively self-select the appropriate actions needed to get the desired results. This mindset has to trickle down from the top.

Encourage positive thinking.

Help employees seek joy in challenging circumstances instead of always looking at the negative. Start by modeling it yourself. When individuals complain about current conditions, help them look at the situation differently. Ask them questions to draw out anything that is going well so they can begin to see it's not all negative. Positive thinking doesn't come naturally to many people, so practice is essential.

Stop the blame game.

We all know people who like to play the blame game—or at least feed into it. Blame kills accountability. Your employees should feel empowered to make mistakes and not be afraid to learn from them. Getting blamed doesn't help anyone. Instead of blaming, managers, leaders, and colleagues should discuss ways to improve processes or projects and allow others to contribute for added buy-in.

Allow creative thinking.

Leaders must allow employees to think creatively to come up with their own solutions rather than solve problems for them. This may seem easy, but it can take time if it isn't a natural part of your leadership style. Learn to ask open-ended questions to prompt problem-solving. Ultimately, you're coaching the individual to create their solutions or devise options to drive personal and team accountability. And, when employees are providing their own answers, they see the value they bring to the organization and engage in responsibilities with more vigor and energy.

Delegate authority.

Once employees begin to demonstrate accountability, give those employees some power to make some decisions. For example, when you assign a project with specific expected results, allow the employees to choose the team, vendor, or tools they will use and work with to get the work done. Give them the ownership they need to get those results.

Bottom line: When you foster an environment where employees are encouraged and expected to focus on personal accountability, you are growing a team of engaged contributors. You'll begin to see a group of more efficient, creative, and independent employees striving to do their best to contribute to the mission, vision, and initiatives of your organization. Culture will naturally improve as trust and camaraderie develop. Lead the way to an enhanced culture and increased engagement through personal accountability!

Integrating Behavioral Health into The Medical Home: A Rapid Implementation Guide

by Kent A. Corso, PsyD, BCBA-D; Christopher L. Hunter, PhD, ABPP; Owen Dahl, MBA, FACHE, LSSMBB; Gene A. Kallenberg, MD; Lesley Manson, PsyD

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How to Manage a Slob

Laura Hills, DA*

Have you ever had to manage a slob, or are you managing one now? Perhaps you have an employee whose workstation is constantly buried beneath stacks of papers and strewn with used coffee cups, snack wrappers, and yogurt containers. Or maybe you have an employee who leaves dishes and mugs in the breakroom sink and spills on the counter, and who leaves food in the fridge until it grows legs and can walk away. Or perhaps you have an employee who arrives at work each day rumpled and wrinkled, like he just rolled out of bed. It can be uncomfortable or awkward to tell an employee that he has a tidiness problem. But that is exactly what the medical practice manager must do. This article argues that tidiness of both physical spaces and personal appearance is a fundamental requirement for medical practice employees. It explores the psychology of slobbery and some of the most likely reasons why an employee may bring sloppy habits to your medical practice. It addresses the importance of being a tidiness role model for your employees and suggests five practices to put in place before approaching a messy employee. It also suggests specific strategies to use when addressing an untidy desk or workspace, an untidy staff kitchen or breakroom, and an employee's untidy appearance. Finally, this article provides six tips for establishing a culture of tidiness and more than a dozen office cleanliness etiquette guidelines for you to share with your employees.

KEY WORDS: **Messiness; untidy; clutter; sloppy; habits; standards; desk; workspace.**

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Is messiness a sign of genius? Some people say it is. As evidence, they will point to geniuses like Thomas Edison, Mark Twain, and Steve Jobs, who kept messy desks.[1] Some will delight in quoting Albert Einstein, who is famously credited with saying, "If a cluttered desk is a sign of a cluttered mind, of what, then, is an empty desk a sign?" They may consider messiness to be an endearing personal characteristic or quirk and an essential part of who they are. They may even take pride in it. And some will go as far as to claim that there are benefits to their messiness. For example, Abrahamson and Freedman[2] suggest, "It's time that we take an open-minded look at messiness in all aspects of our lives and institutions, and consider where it might be best celebrated rather than avoided."

Despite such viewpoints, there is nothing endearing, essential, or worth celebrating about being a slob in a medical practice. Sloppy employees are not sloppy in a vacuum; their mess is experienced by others every day. And much as they may not like it, your employees' potential genius or personal preference cannot give them license to do whatever they want. Quite the contrary. The medical practice manager must hold every employee to standards of conduct, including those related to tidiness and cleanliness. That may seem like a no-brainer. However, there will be some employees who will cling, sometimes ferociously, to their slovenly ways. And there will be those who resent their managers for telling them to tuck in their shirts or to clean up their workspaces, just as teenagers resent their parents for telling them not to leave their dishes in the sink or to clean their rooms. In fact, calling out employees on their slobbery may elicit a strong emotional response. Employees may find it embarrassing to have you speak to them about their messes, and they may react defensively and with anger. As well, employees who have been sloppy for a long time or for their entire lives will probably find it difficult to adopt new habits, even if they want to. And just as having messes pointed out may be troubling to the sloppy employee, you may find having to do so equally distasteful. You may feel that neatness and consideration of others should be a given in a professional workplace.

Many managers feel especially put upon when they find themselves spending their time and energy making sure that their employees pick up after themselves. And who can blame them?

The question is not **if** *you should address the problem with the sloppy employee, but* **how.**

Complicating things further is the fact that some people may believe that their personal tidiness or lack of it is their business, not yours. That may be true in many aspects of your life. For instance, it is not your concern if a fellow passenger on public transportation has wrinkled clothes and a missing button. There is probably not much you can do if you visit your aunt and uncle and find that their home is a cluttered mess. And you probably won't be able to get your next-door neighbor to clean out the gum wrappers and used paper coffee cups that are strewn about the interior of his car. However, your employees' sloppiness is different, because it can damage your medical practice. Patients who encounter a sloppy employee may wonder if the whole practice is sloppy. In many cases, the mess left behind by one employee will cause friction with his or her coworkers and make everyone's job harder. Sloppiness taken to the extreme can create unpleasant odors, attract bugs and rodents, and create safety hazards in your office. Therefore, no matter what an employee tells you, his or her sloppiness is most definitely your business. Do not let the employee convince you otherwise. The question then is not *if* you should address the problem with the sloppy employee, but *how*.

THE PSYCHOLOGY OF SLOBBERY

A good place to begin is to understand why employees are sloppy. One possibility is that the employee does not recognize that there is anything wrong. This is unlikely to be the case for a seasoned employee. However, employees who are new to the workforce may not know what levels of tidiness and cleanliness are expected of them. Rather, they may take their sloppy habits from home and bring them to their first jobs without realizing that they are out of step with their workplace and coworkers. Such problems will be among the easiest for you to address and correct. In many instances, the only thing sloppy new employees may need is your explicit instructions and clear expectations and for you to teach them how to behave in a professional environment.

A more complex psychology may be at play for the seasoned sloppy employee. It is likely that the individual knows that her habits are sloppy, or at least that others deem them so. Most likely the employee has heard complaints before and brought sloppy habits from one job to another. Although in some cases, an employee's slovenliness may be a manifestation of serious, deep-rooted issues that are best addressed through therapy, in most cases, the employee's sloppiness is a manifestation of his or her selfishness. As Dalrymple[3] explains, "The slob is in effect saying to you, and to everyone else, I am not going to make an effort just for you. You must take me as I am, and not think the worse of me for that." Slobbery is not absent-minded, Dalrymple says, as when, for example, a stereotypical absent-minded professor, absorbed in the textual problems of Aeschylus or some such abstruse matter, puts on socks of different colors. As Dalrymple explains, "On the contrary, slobbery is militant. It demands simultaneously that you notice it and take no notice of it." Note, however, that while the slob demands something of you, he demands nothing of himself. It takes no effort to be a slob. In fact, to be a slob is to "indulge in unconditional self-regard," Dalrymple says.

Of course, lack of funds may explain an employee showing up to work with stained or patched clothing or shoes in disrepair. Although such instances may be uncommon, you may be able to resolve them when you encounter them by providing a uniform or giving the employee a small advance on a first paycheck. However, slobbery is more often the result of a psychological issue, not a financial one. As Dalrymple argues, "I have lived in very poor countries in Africa and have been moved by the efforts of very poor people to turn themselves out as well as they can."

In summary, a medical practice manager must ask three questions about a sloppy employee before taking further action:

1. Is this employee new to the workforce and sloppy because he or she does not know what is expected of him or her?
2. Might this employee's sloppiness suggest that he or she has problems that are outside the scope of what I can handle, and are best referred to a therapist?
3. Can this employee's sloppy appearance be attributed to financial problems?

If you answer *no* to these questions, you are dealing with a garden-variety slob. That means that you will need to manage the problem yourself, firmly and effectively. And, as with any employee behavioral issue, you will need to establish clear expectations and enforce them, whether the employee likes it or not.

DO AS I SAY, *AND* AS I DO

Your employees will pay attention to what you do, whether you intend them to or not. As Broudy[4] explains, "You're the role model for your employees. On one hand it means that you're always under the magnifying glass, but the flip side is that being the role model is a powerful management tool."

If you are a disorganized mess, Broudy warns, chances are that your employees will be too.

Take an objective look at your own tidiness before you approach a sloppy employee about his. As Bloem[5] warns, "Don't expect employees to keep their desks uncluttered if your desk is a disaster. 'Do as I say, not as I do' never works." Be sure that your workspace and appearance are as tidy as or tidier than you would expect your employees' appearance and workspaces to be. However, do not spruce up your workspace and appearance just to impress your employees. Rather, improve your tidiness habits for good and maintain them long enough to set a new standard for yourself and for your employees. Doing so will help you to establish credibility when you talk to a sloppy employee about his mess. As well, improving your tidiness will give you an effective way to talk about making such changes from your personal experience. That can carry a lot of weight with your employees who are trying to make similar changes and perhaps finding the task to be difficult.

Sometimes an office slob may be the product of his or her environment. Many of us will pile things onto an already messy tabletop or desk where they will go unnoticed, more so than we will mar a clean surface. As Professional Journey[6] suggests, "Look at your office honestly. Is it conducive to cleanliness?" For instance, do you see unopened boxes or stacks of unread catalogs and journals collecting dust? Are your wastebaskets overflowing? Do your employees have insufficient space to stow their coats and personal possessions? Is your filing space jam-packed? Is your office less than scrupulously clean? If your work environment is less than ideal, declutter and clean it before you do anything else." As Professional Journey suggests, "Start with a clean slate."

CRACKING DOWN ON SLOBBERY

By now you have determined that the tidiness problem in your medical practice is one that is appropriate for you to handle, and you have done all you can to lay a good foundation for tidiness. Now is the time to act. However, no matter how and where you encounter slobbery in your office, you will want to put several practices into place. First, remember that you don't need to break an egg with an axe. A gentle reminder to be tidier may be all that the messy employee needs. Start there and give your employee a chance to do better. Second, respect the employee's privacy. As Petersen[7] suggests, "Don't reprimand the employee in front of co-workers." Meet with him or her privately. Third, don't make it personal or a value judgment. Instead, Petersen suggests framing the discussion as concern for the office community as well as for your employee's career. Or, as Professional Journey suggests, "Make it about work impacts." Fourth, listen and pay attention. It may be that the employee also has concerns about the condition of her workspace as well as her own organizational skills. She may need reassurance and instruction, not discipline. Or, the employee may offer a valid reason for the mess, such as that she does not have sufficient space for necessary equipment and paperwork. She may need you to find more space in a filing cabinet or come up with another solution. Finally, don't single out any employee unless you are sure that he or she is the culprit and that he acted alone. Sometimes office messes are co-created. You may have to do some sleuthing to figure out precisely what has been going on. If the problem turns out to be widespread, you will want to address the problem with your entire staff.

There are three basic types of slobbery that plague a professional workplace: the messy desk or personal workspace; the messy kitchen, breakroom, or other shared space; and the messy personal appearance. We will explore each of these separately below.

The Untidy Desk or Workspace

Some employees will find it difficult to keep their desks tidy because they handle more paper than they can store. There are three possible solutions to this problem. The first, as already suggested, is to identify or create additional storage space in your office. The second is to reduce your files by eliminating what you can and storing rarely needed files off site. While both solutions can help, they may not solve the problem permanently. Paper has a way of creeping back into an office and filling up vacant space. Therefore, Boitnott[8] suggests the third solution: reducing your paper-heavy processes. As Boitnott explains, "By closely examining the processes that are creating such a large amount of paper, you may be able to find an easy solution." Many software solutions are available that can replace paper and help your employees to keep their desks tidier.

In many cases, however, the problem will be not the volume of paper but the employee's poor habits. If the employee seems teachable, work with him so he can learn how to organize his desk and his work. Follow up and look for and reinforce steady progress. If you sense that the employee doesn't care to improve his behavior or is being intentionally sloppy, treat the problem as you would other employee behavioral problems. Document everything you observe and complaints others share with you. Take photographs of the mess when you can. Then, work your way through a series of verbal and written warnings that spell out what you expect, by when, and the consequences if the employee doesn't improve. Ultimately, an employee who can't or won't meet your expectations about tidiness is probably not a good fit to your medical practice.

However, before you fire an employee for her messy desk, Professional Journey suggests that you try one last strategy. As Professional Journey explains, "Nothing freaks out messy people more than the threat of you taking ownership of a situation and cleaning up their mess, in front of everyone. Confronting? You'd better believe it!" If you want

Establish a Culture of Tidiness: Six Tips

What your office looks like is a direct representation of your work culture. As Herold[13] suggests, "It's the physical embodiment of your beliefs, your standards and your theories on how to treat your employees and run your business." Great workplace culture begins with a clean, uncluttered office, Herald says. Here are six tips to help you create a culture of tidiness in your medical practice:

1. **Stow work papers and tools.** Some people like to work with many of the papers and supplies they need on view at once. In this way, they have much in common with woodworkers who hang their tools on display in a workshop. For example, some employees like to have bulletin boards in their offices covered with various papers. Or, they may like to erect large desk-top file holders and jam them with dozens of files. Or they may like to keep every office supply they could possibly need on their desks. However, a less cluttered office, and one that is easier to keep physically clean, is one in which most items are stored in drawers and behind closed cabinet doors. Establish a culture in your office in which employees keep their work papers, tools, and supplies stored when they are not using them. For example, if they rarely use a ruler or a staple remover or a hole puncher, those items should be stored in the desk drawer, not on the desk. Likewise, if an employee is working on a file only occasionally, or is done working on it, it should be kept in a file drawer or cabinet until it is needed again. The overarching goal should be to limit the number of items on a desk or other surface to the essentials.
2. **Establish cleaning rituals.** Make tidying up a regularly scheduled communal activity. For example, Petersen[7] suggests, "Encourage employees to develop the habit of tidying and cleaning their desks at the end of the workday." Or, as Herold suggests, make every Wednesday a "wasteless Wednesday," with everyone pitching in to keep things looking clean and neat. Or, as Petersen suggests, hold end-of-day clean-up parties so that employees have paid work time to rid themselves of whatever they don't need. If the mess will take longer to clean up than will fit in such time, Boitnott[8] suggests devoting an entire day to it. "Play music, bring in food for lunch and allow all employees to wear casual clothes," Boitnott says.
3. **Provide cleaning supplies.** Even if you have a cleaning service, make sure that your employees have the tools and equipment they need conveniently on hand to keep your office clean throughout the day. For example, Petersen suggests that you keep your office break room stocked with paper towels, dusters, and spray bottles of all-purpose cleaner. As well, keep a vacuum cleaner or broom on hand.
4. **Encourage employees to keep personal care supplies on hand.** Things can happen during the day that can mar an employee's appearance. Encourage employees to keep in the office whatever grooming supplies or changes of clothing they will need to keep their appearance clean and tidy. Be sure they have a place to stow their supplies. As well, keep on hand some supplies for general use such as stain remover, nail polish remover, a sewing kit, safety pins, and a lint brush.
5. **Establish a place for everything.** Things will be left out on counters and desks when there is no good place to put them. Establish "homes" for everything and make them easy to use. Davis[14] suggests taking ergonomics into account. As Davis explains, "Commonly used items should be stored within easy reach, reducing the need for bending, stretching and excessive walking." If you can't identify good homes for new items, ask your staff to help you find them.
6. **Provide what employees need to stay organized.** Office supply catalogs, websites, and stores offer an array of products that can help your employees to organize their workspaces. These include organizers for drawers, cabinets, closets, and your break room. Offer to approve purchase of organization tools that your employees think will help them. However, be mindful not to choose items that will create more clutter or that don't serve a needed purpose. Rather, purchase items that will maximize limited storage space or that will create needed systems.

to give this strategy a try, Professional Journey suggests that you send an email to the messy, thoroughly warned employee stating that she has until close of business to have a clean desk or workspace. Then explain that you'll be at her desk first thing the next morning, before your office opens, with a plastic bag in hand, and that you will slide everything messy into the trash. "Sometimes fear and shame are great behavior change motivators," Professional Journey says. Although this strategy is not for everyone, Professional Journey suggests that it is much like ripping off a Band-Aid because it shortens the pain. After your clean-up, the ball will be in the employee's court. She will get the message and keep her desk tidy from then on. Or she will continue her slobbery, in which case you will likely want to fire her.

The Untidy Kitchen, Breakroom, or Other Shared Space

If you are fed up with the piles of dirty dishes in your office kitchen, you are in good company. According to Egan,[9] many employers struggle with this problem. As Egan explains, "Since the kitchen is a common space, some workers may [mistakenly] believe it's someone else's

Office Cleanliness Etiquette Guidelines

Your office slob will have a better chance of understanding what you mean by a clean, tidy office if you provide everyone with guidelines. Below are examples of employee tidiness guidelines used in other offices.

- Keep your work area as neat and clutter-free as possible during the workday. Secure sensitive materials before you leave your desk. Clear or organize your desk at the end of each workday.
- Keep cords for computers and other equipment neatly bundled and safely out of the way.
- Do not store materials on the tops of cabinets or under your desk. Leave these spaces clear so they look uncluttered and can be easily cleaned.
- Limit personal items on display in your workspace to no more than a specified amount (typically one to three). These must be small and appropriate for workplace display and not offensive to your coworkers or other visitors. Personal objects, if allowed, must be kept clean. If you have a houseplant or flowers on your desk, they must look healthy and be pest-free. Do not allow fallen leaves or petals to remain on your desk or the floor. Protect surfaces from water damage.
- Do not eat at your desk. Eat only in designated areas and only during lunch or breaks, unless you have permission to do otherwise.
- You may have beverages at your desk if they do not interfere with your work, if they are in plain lidded cups or bottles, and if you use a coaster to protect your work surface. Do not allow used, dirty cups or bottles to accumulate on your desk.
- Discard food wrappers, disposable cups, uneaten food, and similar food and drink items in designated waterproof containers lined with plastic bags. Use wastebaskets only for dry office paper waste.
- If trash containers are overflowing, empty them. Do not stack trash on the floor.
- Do not hang items on walls such as posters, paintings, inspirational quotes, or photographs without permission to do so. Do not tape items to walls, doors, or cabinets without permission. Do not bring seasonal or celebratory decorations for display in the office without permission.
- Do not store stacked materials or boxes on the floor, on chairs, on top of equipment, or on other surfaces. Stow these items in appropriate storage furniture or areas.
- Do not leave trash or personal items behind in our restrooms, kitchen, or other shared spaces. Quickly scan shared spaces before you leave them to be sure that you don't leave anything behind.
- Keep our kitchen clean and neat. Do not leave dishes in the sink or on the counter. Remove food you bring to work promptly from our refrigerator. Clean the kitchen table, counter, and other surfaces as needed after you have used them.
- Do not leave cooked food sitting in the microwave. Remove it as soon as it is finished cooking.
- If you make a mess, clean it up. Do not leave it for later.
- If you use the last paper towel, sheet of toilet paper, coffee stirrer, coffee creamer, or other supply, replenish its holder or container.
- Report anything that is dirty or in disrepair that you cannot clean or fix. If you break something, clean and secure it so it is not a hazard and report that too.
- Dispose of shipping boxes and packing materials promptly and in the designated place.

responsibility to keep it clean and organized." Therefore, you will need and want to put the record straight. Egan suggests that you create and post rules for your kitchen such as that no dishes be left in the sink, that spills be cleaned up immediately, that trash be put in the receptacles you provide, and that employees refill anything that they've emptied, such as the coffee pot or the paper towel dispenser. You can buy ready-made signs about general kitchen rules and also others that focus specifically on refrigerator and microwave etiquette. For example, you can find a variety of plastic, aluminum, laminated label, or magnetic kitchen signs for your office at www.mydoorsign.com. Keep in mind, however, that most die-hard slobs will ignore rules and signs. Employees who continue to leave a mess in your office kitchen despite your series of warnings probably do not belong in your medical practice. Their lack of consideration for others eventually will eat away at the rest of your staff, who want to eat their lunches and take their breaks in a clean kitchen. In addition, some kitchen messes pose a health risk not worth taking.

Untidy Personal Appearance

Managers tend to agonize over conversations about dress and grooming because the problem is so personal. Employees may feel embarrassed and offended when you talk to them about their dirty, wrinkled, and stained clothing and their messy hair. However, Green[10] suggests that you enter such conversations from a depersonalized point of view. As Green says, "It's not about him as a person or a condemnation of his personal style choices." In fact, the employee who dresses and grooms like a slob may have no problems doing so in his personal life. Therefore, Green suggests, focus on the fact that what he is doing or not doing with the way he presents himself is not appropriate for

his job in your medical practice. It will be helpful for you to look at this like any other feedback conversation with an employee. As Gallo[11] suggests, broach the subject with the employee by framing it as feedback. For example, you can say, "I want to give you feedback on your overall presence and make sure that your appearance is aligned with the high-quality professional work we expect in our medical practice." Then talk with the employee as you would if it were any other behavior that you would like to see change in his work. As Green suggests, simply say, "Here's the issue, here's what I need you to do differently to solve it." Once again, follow up and hold firm in your expectations. Use your documentation, photographs when possible, and repeated verbal and written warnings to make the consequences clear to the employee who will not change.

A KINDER, GENTLER WAY TO CONFRONT UNTIDINESS

There will be incorrigible workplace slobs who will not change their ways no matter what you do. In this article, we have explored firm employee management strategies that can be very effective. However, a great many employees are very good at their jobs and just need to tidy up a bit. For them, a kinder, gentler approach may be most effective. Here is one that puts you less in the position of a boss and more in the position of a mentor.

To begin, acknowledge that the topic you are about to discuss is awkward, both for the employee and for you. As Belding[12] suggests, start off by saying something like, "John, this is really awkward," or "Lucy, there's something I think you may want to know, and it's kind of awkward." Starting out this way helps you share in the employee's awkwardness. It is also an act of kindness. The employee may not know why you have asked to speak with her. This is a kind way to begin because it gives her a moment to brace herself for what is about to come.

Next, describe what the problem is and share your genuine concerns about the employee. For example, Belding suggests, say something like, "I'm concerned about the clutter in your workspace. People are going to get the wrong impression—that you don't care about what you do . . ." If you've seen a radical change in the employee's habits recently, say so, and, again, express your concern. The key here is not to minimize the problem or to say anything that is untrue. Your tone, facial expressions, gestures, and words must ring true or it will seem to the employee that you are not sincere. If that happens, the employee will shut down.

Of course, you've got to stick to the facts, and you need to be clear about what needs to change, just as you would when managing any employee behavioral problem. However, what happens after that is crucial: you've got to give the employee a way to save face. Reaffirm your genuine respect for her and your appreciation for the good work she does. Let her know that while you may have found something in her behavior that needs to be corrected that it can be, and that it hasn't lessened your opinion of her. For example, Belding suggests, say something like, "I know you care about the quality of your work—but other people don't know you as well as I do." As Belding suggests, "The benefit of this process is that if you do it right, you can address potentially sensitive issues in such a way that minimizes the potential for offending or alienating people." Try this approach with a good and valued employee who just needs to tidy up a bit and see if that does the trick.

REFERENCES

1. James G. A messy desk is a sign of genius, according to science. *Inc.,* July 9, 2017. www.inc.com/geoffrey-james/a-messy-desk-is-a-sign-of-genius-according-to-scie.html. Accessed May 23, 2020
2. Abrahamson E, Freedman DH. *A Perfect Mess: The Hidden Benefits of Disorder—How Crammed Closets, Cluttered Offices, and On-the-Fly Planning Make the World a Better Place.* New York: Back Bay Books/ Little, Brown, and Company; 2007.
3. Dalrymple T. The horrors of self-esteem: why self-esteem is a bad idea. *Psychology Today.* August 28, 2015. www.psychologytoday.com/us/blog/psychiatric-disorder/201504/the-horrors-self-esteem. Accessed May 23, 2020.
4. Broudy J. Be a role model for your employees. *Contractor.* March 1, 2010. www.contractormag.com/management/article/20874316/be-a-role-model-for-your-employees. Accessed May 23, 2020.
5. Bloem C. Is your employee's messy desk destroying productivity? Here's an emotionally intelligent fix. *Inc.* November 27, 2018. www.inc.com/craig-bloem/is-your-employees-messy-desk-destroying-productivity-heres-an-emotionally-intelligent-fix.html Accessed May 23, 2020.
6. Professional Journey. 5 tips for dealing with the "office slob" in your workplace. Professional Journey. November 26, 2014. www.professionaljourney.com/2014/11/26/office-slob-workplace/. Accessed May 23, 2020.
7. Peteresen L. Addressing a messy work station to an employee. The Nest. https://woman.thenest.com/addressing-messy-work-station-employee-4940.html Accessed May 26, 2020.
8. Boitnott J. How to handle untidy, messy employees. *Inc.* November 12, 2014. www.inc.com/john-boitnott/how-to-handle-untidy-messy-employees.html. Accessed May 26, 2020.
9. Egan J. 6 ways to combat kitchen chaos at the office. HuffPost. December 6, 2017. www.huffpost.com/entry/6-ways-to-combat-kitchen-_b_5504251. Accessed May 26, 2020.
10. Green A. Ask a boss: my employee dresses like a slob! The Cut. July 12, 2016. www.thecut.com/2016/07/ask-a-boss-my-employee-dresses-like-a-slob.html. Accessed May 27, 2020.
11. Gallo A. How to give an employee feedback about their appearance. *Harvard Business Review.* May 26, 2017. https://hbr.org/2017/05/how-to-give-an-employee-feedback-about-their-appearance. Accessed May 27, 2020.
12. Belding S. A surprisingly effective way to deal with the office slob. Winning at Work. August 2015. https://winningatwork.beldinggroup.com/a_surprisingly_effective_way_to_deal_with_the_office_slob/. Accessed May 27, 2020.
13. Herold C. Great company culture starts with a clean office. American Express. May 11, 2012. www.americanexpress.com/en-us/business/trends-and-insights/articles/great-company-culture-starts-with-a-clean-office/. Accessed May 26, 2020.
14. Davis K. 5S: A place for everything and everything in its place. James Moore. www.jmco.com/5s-lean-six-sigma/. Accessed May 26, 2020.

Assessing Psychiatric-Related Work Disabilities in Primary Care Practice

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Because many psychiatric patients are seen in primary care settings, insurance companies rely heavily on primary care medical records to determine whether patients qualify for psychiatric-related work disabilities. Accurate and complete documentation of psychiatric diagnoses, substantiated by the clinical content of office notes and collateral sources of information, is paramount in establishing the presence of a disability. Insurance companies specifically consider observations regarding the patient's mental status, including any cognitive abnormalities, and the impact of the patient's psychiatric disorder(s) on day-to-day activities. The severity of psychiatric symptoms, performance deficits at work, an assessment of the patient's overall functioning, and the intensity of mental health treatment also are considered in disability determinations. The insurance claim file, which contains medical records submitted by primary care providers and, possibly, other health providers, should demonstrate objective findings that psychiatric conditions are causing global impairments and functional limitations requiring medically necessary activity restrictions at work.

KEY WORDS: **Psychiatric disability; mental illness; impairments and limitations; performance deficits; activity restrictions; work accommodations.**

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Mental illnesses and substance use disorders are among the most common causes of long-term disability in the United States, preceded only by musculoskeletal disorders, cancer, and pregnancy.[1] Primary care physicians (PCPs) play a significant role in the determination of psychiatric-related work disabilities, because more adult Americans receive mental health treatment from PCPs than from psychologists or psychiatrists.[2] PCPs often lack the time, training, and resources, however, to explore their patients' psychiatric-related impairments and the effects of psychiatric disorders on their patients' ability to perform at work.[3]

DENIED CLAIMS

Because it may be difficult for PCPs to make a compelling case for a psychiatric disability, it is not surprising that about one-third of initial claims for all causes of long-term disability are denied by private insurance companies.[4] The most common reason is that the information requested by the insurance company was not received or is inadequate. Although it is not known how the rejection rate for individuals with mental illnesses compares with the overall rate, taking into account physically based claims, mentally ill individuals often have a particularly difficult time obtaining disability benefits. Apart from inadequate or missing information, there may be diagnostic and preexisting condition limitations in insurance policies, and symptom variability in psychiatric patients makes it very difficult to predict treatment outcomes and project a date when the patient may return to work.

When insurance companies make disability determinations, whether for mental health claims or non–mental health claims, they typically request office progress notes and collateral information contained in primary care medical records (e.g., consultations, lab results, and imaging studies). Primary care medical records may or may not contain valuable information about the patient's mental status and psychosocial functioning. Nevertheless, insurance companies rely heavily on primary care medical records for psychiatric disability determinations. (Of course, records of psychiatrists and psychologists also are requested and reviewed, if available.)

PERFORMANCE DEFICITS

Disability benefits are awarded based on the impact a condition has on an individual's ability to perform activities essential for a defined job. Insurance companies not only send written requests to PCPs for their medical progress notes, but typically send forms that ask questions such as "Why is your patient unable to work at present?" and "What specific activities or tasks is your patient unable to perform that affect his or her ability to work?" The PCP must have some knowledge of the tasks involved in the patient's job to answer those questions.

Document review may reveal misrepresentations by healthcare providers due to bias or attempts to justify diagnostic and therapeutic interventions.

Any patient may report that a mental disorder prevents him or her from working. However, such statements must be medically verified. If the medical record or responses to the insurance company's inquiries do not contain documentation corroborating that the patient actually is unable to perform work-related activities, then the odds of that patient qualifying for a mental health disability are low. Furthermore, document review may reveal misrepresentations by healthcare providers due to bias or attempts to justify diagnostic and therapeutic interventions. Thus, accurate assessment of the validity of the clinical presentation and other validity considerations is taken into consideration during claim file reviews.

PCPs usually are able to document information related to their patients' temperaments and aptitudes as a proxy for work ability and impairment. For example, they can provide information about the patient's ability to think clearly and articulate facts and ideas. They can discuss whether the patient can follow specific instructions, as well as direct, control, and plan activities. Patients with mental health disabilities usually demonstrate severe limitations understanding, remembering, or applying information, as well as adapting to change and interacting with others. A mental health disorder affecting a patient's ability to interact and cooperate with others, handle conflicts, and respond to suggestions and correction may be indicative of psychiatric-related work disability.

Although patients with personality disorders often demonstrate interpersonal conflicts, the notion that work and experiences at work are the relevant causative factors for any manifestations of distress or impairment is ambiguous, at best. Personality disorders are, by definition, relatively fixed ways of behaving that arise in childhood or adolescence, long before an adult workplace event. Patients with borderline personality disorder, in particular, are very sensitive to environmental circumstances, especially at work. Yet, most patients with borderline personality disorder rarely meet insurance company criteria for a mental disability.[5]

SOURCES OF INFORMATION

The psychiatric insurance claim file usually contains medical records submitted by a psychiatrist, psychotherapist, PCP, and sometimes other physicians and healthcare providers (e.g., physician assistants, nurse practitioners, and physical and occupational therapists). Insurance companies may request supplemental information on insurance company forms designed to capture important information not found in the medical records. Occasionally, insurance companies ask patients to undergo independent medical evaluations by expert physicians who are not involved in their treatment.

Inconsistent documentation among caregivers regarding a patient's mental health functioning, such as differences in opinions and diagnoses, incorrect or contradictory information, or information that cannot be substantiated, will cast doubt on the issue of genuine, severe psychopathology. It also will damage the credibility of the patient's statements to his or her providers or the providers' accuracy in reporting the patient's symptoms, such that a functionally impairing psychiatric condition cannot be established with certainty. The presence of significant inconsistencies will lead insurance companies to consider the possibility of secondary gain or exaggeration of the patient's psychological dysfunction.

SYMPTOM SEVERITY AND GENERAL FUNCTIONING

Because psychiatric disabilities are the result of significant symptomatology, symptoms should manifest as severe and beyond mild to moderate in intensity for an individual to be considered incapable of working. To be sure, rating the severity of symptoms is a subjective process. Rating scales for conditions typically associated with mental health disabilities, such as depressive and anxiety disorders and posttraumatic stress disorder, may be useful in gauging the severity of symptoms, as long as the testing contains objective validity scales to assess the patient's current symptoms.

Because symptoms are indicators of the severity of the patient's mental health conditions, it is crucial that the frequency, intensity, and duration of specific symptoms be documented. Documentation in the medical records should reflect that the symptoms are severe enough to interfere with the patient's occupational role and

Table 1. Domains of Functional Assessment

Mental functions that most often impact work capacity	
Social competence and teamwork	How well does the patient communicate, collaborate, and cooperate with peers, subordinates, and authority figures at work?
Adaptability/flexibility	Can the patient change perspective in response to changing demands at work?
Conscientiousness/dependability	Can the patient be consistently relied upon to perform the duties and responsibilities of the job?
Impulse and behavioral control	How well controlled are the patient's impulses, especially anger and aggression (realize, however, that any impaired capacity to control behavior can preclude work)?
Integrity	Is there consistency between the patient's words and actions? Does the patient "walk the walk" in addition to "talking the talk"?
Emotional regulation	Can the patient modulate emotional responses so that reactions to different situations do not interfere with job-relevant functions?
Decision-making and judgment	Does the patient possess the relevant knowledge and understanding to perform the job? Does the patient have the sound judgment to examine the relevant facts in a specific situation to be able to make a good decision?
Risk-taking behavior	Does the patient take excessive risks that can be considered dangerous? Could patients working in safety sensitive jobs—e.g., law enforcement, firefighting, medicine—potentially harm individuals?
Cognition	If cognitive impairment is present, can the specific job-relevant cognitive function that is disrupted be identified?
Self–monitoring	Does the patient have insight into his or her behavior? Is the patient aware of attitudes and feelings that may negatively affect other individuals in the workplace?
Other domains that warrant attention	
Planning	
Prioritization	
Task initiation and monitoring	
Time management	

Adapted from Long B, Brown AO, Sassano-Higgins S, et al. Functional assessment for disability applications: tools for the psychiatrist. *Psychiatric Times.* 2019;36(6):19-20.

responsibilities. Table 1 outlines specific mental functions that most commonly disrupt an individual's capacity to sustain work.

STRESS

A common misconception among caregivers is that patients should qualify for time off from work due to stress. However, realistically, no job has ever been stress-free, and there is no individual whose personal life has always been free of stress. Stress-related problems in living usually do not justify a finding of mental health disability, including financial stress due to unemployment and social hardships, as well as stress compounded by the actual denial of a disability claim.

When assessing the relation between stress and work performance, the PCP should determine whether an underlying mental illness is the cause of work-related impairment, or whether stress from work is the cause of psychiatric symptoms. If the latter, insurance companies are unlikely to approve the claim, because workplace stress and dissatisfaction are common and not, in themselves, an indication of mental illness or impairment.

> ***A bad fit between an individual and a workplace does not constitute a mental health disability.***

Complaints that derive from issues such as conflicts with a supervisor or coworker, heavy workloads, or a wish to take time off from work for personal reasons, must be separated from symptoms due to mental illness. A bad fit

between an individual and a workplace does not constitute a mental health disability. When disgruntled individuals seek employment elsewhere, their job search may be considered prima facie evidence that psychiatric impairments and limitations do not preclude work.

REFERRALS

Although PCPs are adept at providing counseling and psychotropic medication for uncomplicated psychiatric patients, more seriously ill individuals usually require a referral to a psychiatrist or psychologist, or both. Insurance companies look to see if a referral has been made. If there is no documentation that the patient currently is receiving treatment by a mental health professional, it may signal that the PCP's treatment, although appropriate, lacks the intensity of therapy considered prerequisite for a disabling mental illness. Insurance companies generally expect that a patient will have required intensive outpatient therapy or "partial" or inpatient hospitalization for a condition causing a major psychiatric-related work impairment.

ACTIVITIES OF DAILY LIVING

Until proven otherwise, it is assumed that patients are capable of eating, bathing, dressing, grooming, and performing other routine activities related to personal hygiene and self-care—the so-called activities of daily living (ADLs). More complex skills, such as managing finances and medication, preparing meals, driving, and utilizing a computer and personal digital assistants, are known as instrumental activities of daily living (IADLs). Both ADLs and IADLs should be documented in the medical records as intact, or not.

It would be expected that a mental disorder severe enough to prevent performance of all work activities also would cause notable impairments in most or all other life activities, often referred to as a *global psychiatric impairment.* It is very unlikely that a mental disorder severe enough to preclude work would not affect ADLs and IADLs.

WORK RESTRICTIONS AND RETURN TO WORK

After careful consideration of the patient's psychiatric and medical diagnoses, mental status examination, performance deficits, cognitive abnormalities, severity of symptoms, intensity of treatment, global assessment of functioning, ADLS/IADLs, and other factors, PCPs should be able to decide whether psychiatric-related work restrictions are medically necessary. Such decisions may result in life-changing events and, therefore, should be given very serious consideration.

Comprehensive restrictions such as "no work" and "permanently disabled" usually are not supported by insurance companies, because those terms are overly broad and too vague, and they are not correlated with specific clinical impairments and limitations. Reasonable psychiatric restrictions may include the following:

- Low project responsibility;
- Minimal supervision of others;
- Reduced or flexible work hours;
- Minimal interaction with the public; and
- No handling of dangerous machinery.

PCPs should limit their restrictions to the functional impact of the psychiatric disorder. Any restrictions indicated by comorbid medical conditions should be made separately. For example, in an individual with depression and low back pain, restrictions related to sitting, standing, walking, reaching, lifting, carrying, climbing, and stooping usually are not relevant to the psychiatric component of the disability.

Some mental illnesses may warrant driving restrictions, although this is a controversial issue.[6] Driving usually is considered a privilege unrelated to the capacity to work. Patients who should not be driving for psychiatric or medical reasons, or who should be driving only under certain circumstances, should be informed by their physicians. However, driving restrictions due to medical and psychiatric conditions preclude only employment as the operator of a motor vehicle, not all gainful employment,.

RISK FACTORS

The major risks of returning a mentally ill individual to work are acting out in aggressive or violent ways, and possibly harm to self or others due to inattention or poor judgment. The potential for cognitive impairment leading to harm to self or others requires close scrutiny of individuals who use dangerous machinery or are employed in the healthcare profession and are at risk to make medical mistakes.

Workplace violence, an all-too-common event on the nightly news, is essentially unpredictable. However, a personal history of violence or repeated violence is a significant risk factor for future violence. Risk factors for violence specific to work include feeling isolated or picked on by supervisors and being treated unfairly or particularly inhumanely at termination.[7]

WORK ENVIRONMENT

It is undisputed that changes in the work environment can lead to significant improvements in worker well-being. The responsibility for disability management does not rest solely on the insurance carrier or claims administrator; rather, it is shared with the employer. The employer is expected to create an environment of awareness, support, and tolerance to ensure that workers lead more successful and productive lives, whether or not they have a mental

disorder. Employers must foster an overall culture of wellness that is reinforced by senior leadership. Organizations increasingly are turning to chief wellness officers to promote worker well-being. Studies[8] have shown that modifiable work-related risk factors such as low job control and high job strain are important targets in efforts to reduce mental afflictions and disability claims.

The longer a patient remains on disability, the less likely he or she is to return to work.

Prevailing (and stigmatizing) views that mentally ill patients cannot or should not work are unfounded. Research has demonstrated that working does not have an adverse effect on mental illness in the overwhelming majority of cases.[9] To the contrary, work tends to have a salutary effect on individuals with mental illnesses. Working enhances psychological health and well-being, promotes a connection to the broader social and economic community, and also provides a means for individual satisfaction and accomplishment. Conversely, the loss of work has been associated with a variety of mental health ailments and societal problems, including crime, substance abuse, and family dissolution. Thus, early return to work should be a priority for patients on disability leave.

In addition, the longer a patient remains on disability, the less likely he or she is to return to work. Fear of relapse upon reintroduction of stable or recovering patients into the workforce usually does not warrant medically necessary work restrictions, because, as stated earlier, most psychiatric disorders are attenuated or ameliorated by work. Staying at work or returning to work is almost always in the patient's best interest.

APPEAL PROCESS

Insurance company claims managers are trained to decide disability benefits based on the clinical data and accounts contained in the medical records, as well as medical opinions solicited from insurance company physicians and independent physicians, when requested. Benefit decisions must be aligned with the provisions set forth in insurance policies. PCPs and patients understandably can become angry and upset when a decision is unfavorable. Appealing insurance claim denials can be a complicated and frustrating process that often is difficult to understand and navigate.

Both the patient and the PCP may submit additional information to consider during an appeal. The same documentation standards apply—that is, to submit objective and detailed mental status and behavioral observations and findings related to global functioning. Clinical updates sent to insurers, whether documented in progress notes or written on the PCP's letterhead, should emphasize the most recent events that substantiate the medical need for work restrictions.

Information submitted on appeal is scrutinized by insurance company personnel who have varying backgrounds and, therefore, should be written in non-technical terms for a general audience. In all instances, the tone of progress notes, evaluations, letters, and other correspondence should be professional, without hyperbole, rancor, or ranting. The newly submitted material should be free of bias and grounded in medical findings and observations.

CONCLUSION

PCPs are the vanguard to the evaluation of work ability and return-to-work decisions. Psychiatric-related work disabilities are characterized by: (1) psychiatric symptoms that cause global impairments; (2) impairments that result in functional limitations; and (3) performance deficits specifically related to psychiatric impairments and limitations. When all three conditions are met, medically necessary work restrictions usually are appropriate.

The most effective disability assessments focus on identifying the precise work-relevant impairments and limitations; explain why the recommended restrictions are necessary; and discuss how treatment can be reasonably expected to reverse the impairment and, in doing so, return the patient to work within a reasonable time frame.

REFERENCES

1. Council for Disability Awareness. Disability Statistics. https://disabilitycanhappen.org/disability-statistic/.
2. Reiger DA, Goldberg ID, Taube CA. The de facto mental health services system: a public health perspective. *Arch Gen Psychiatry.* 1978;35:685-693.
3. Taiwo OA, Cantley L, Schroeder M. Impairment and disability evaluation: the role of the family physician. *Am Fam Physician.* 2008;77:1689-1694.
4. American Council of Life Insurers. www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AB39-2/00186.pdf.
5. Skodol AE, Gunderson JG, McGlashan TH, et al. Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. *Am J Psychiatry.* 2002;159:276-283.
6. Holoyda BJ, Landess J, Scott CL, Newman WJ. Taking the wheel: patient driving in clinical psychiatry. *Psychiatr Ann.* 2018;48:421-426.
7. Resnick PJ, Kausch O. Violence in the workplace: role of the consultant. *Consulting Psychology Journal: Practice and Research.* 1995;47:213-222.
8. Harvey SB, Sellahewa DA, Wang MJ, et al. The role of job strain in understanding midlife common mental disorder: a national birth cohort study. *Lancet Psychiatry.* 2018;5:498-506
9. Blustein DL. The role of work in psychological health and well-being: a conceptual, historical, and public policy perspective. *Am Psychol.* 2008;63:228-240.

Proposed Stark Regulations: Small Step in the Right Direction

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The Ethics in Patient Referrals Act, known as the Stark Law, was designed to prohibit physicians (or their immediate family members) who have a financial relationship with a healthcare entity from making Medicare referrals to those entities for the provision of designated health services. Despite several "exceptions," the law is a major hurdle to achieving value-based healthcare reforms. The Centers for Medicare & Medicaid Services (CMS) recently issued a highly anticipated proposed rule that seeks to establish new exceptions and definitions, and provide additional flexibility to support the current shift in the U.S. healthcare delivery and payment system from volume-based to value-based reimbursement. This article summarizes the proposed exceptions and discusses their proposed changes to the definitions of the "Big Three" Stark Law exception requirements—fair market value, commercial reasonableness, and the volume or value standard—and potential implications for physicians.

KEY WORDS: Stark Law; value-based care; price transparency; employment models; Anti-Kickback Statute.

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Concern about physicians' decisions placing financial rewards above patient interests led Congress in 1988 to pass the Ethics in Patient Referrals Act, also known as Stark I, named after the sponsor of the bill, U.S. Rep. Pete Stark of California.[1]

The Stark Law governs those physicians (or their immediate family members) who have a financial relationship (i.e., an ownership investment interest, or a compensation arrangement) with an entity, and prohibits them from making Medicare referrals to those entities for the provision of designated health services (DHS).[2]

The law includes a large number of exceptions related to ownership interests, compensation arrangements, and forms of remuneration.[2] These exceptions were necessary to prevent legitimate transactions from being open to prosecution under the Stark Law.

Similar to Stark, the federal Anti-Kickback Statute (AKBS) was established to prevent intentional abuse of the healthcare system to realize financial gain. Physicians can take advantage of "safe harbors" and exempt certain arrangements from its prohibitions. This differs from the Stark Law in that, under AKBS, a financial relationship outside a safe harbor is not necessarily illegal, whereas under the Stark Law, a relationship must fit into one of the many regulatory exceptions to avoid prosecution.[1]

During the past three decades, physicians have practiced in fear of violating (even unintentionally) these fraud and abuse laws, as the federal government prosecutes physicians for unintentional violations, including documentation errors, for their financial relationships with other physicians who make referrals for DHS. Furthermore, whistleblowers or *qui tam* plaintiffs can sue physicians for alleged Stark Law violations under the False Claims Act, thereby resulting in treble damages and other penalties.

In a recent survey of 162 healthcare chief executive officers and executives, 36.2 percent pointed to fraud and abuse laws that don't support new models of care as standing in the way of improving healthcare.[3]

PROPOSED MODERNIZATION OF STARK

On October 9, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to modernize and clarify the Stark Law. The proposed rule changes were published in conjunction with the Office of Inspector

General (OIG) of the Department of Health and Human Services (HHS), which published proposed rule changes to the AKBS.[4]

Historically, the application of the Stark Law (and the AKBS) has, at times, been at odds with the goals of healthcare reform. Specifically, the discord between the objectives of fraud and abuse laws, and the objectives of value-based reimbursement models reflected the disjointed approach to healthcare reform by the numerous federal agencies tasked with regulating the healthcare industry.

For example, HHS and CMS have pushed value-based healthcare initiatives, which require provider alignment and collaboration, while the OIG and the Department of Justice (DOJ) have intensely scrutinized these arrangements as they relate to the Stark Law and AKBS, and their potential liability under the False Claims Act. Ultimately, this disjointed approach resulted in a scenario wherein the left hand didn't know what the right hand was doing.[5]

Under the proposed rule, CMS seeks to establish new exceptions and new definitions, as well as provide additional flexibility to support this necessary evolution of the U.S. healthcare delivery and payment system. This article will summarize the new Stark Law exceptions proposed by CMS and discuss their proposed changes to the definitions of the "Big Three" Stark Law exception requirements: fair market value, commercial reasonableness, and the volume or value standard. The potential implications of these rule changes on physicians, including how the proposed rule may reduce current regulatory burdens on providers and influence hospital/physician arrangements going forward, are also addressed.

PRIME REASONS FOR CHANGE

The majority of the proposed changes to the Stark Law acknowledge the shift of healthcare reimbursement from volume-based to value-based payment models and seek to accelerate it.[6] Hence, the prime reasons behind the change are adopting value-based care, promoting coordinated patient care, and fostering improved quality, better health outcomes, and improved efficiency and clarity in how the Stark Law relates to new forms of reimbursement and bonus sharing, telemedicine, and accountable care organizations.

Under the proposed rule provisions, CMS aims to adopt new Stark Law exceptions and revise or reconsider certain existing Stark Law definitions and exceptions. The stated intent of these changes is to: (1) alleviate the undue impact of the Stark Law on parties that participate in alternative payment models; (2) facilitate care coordination; and (3) balance genuine program integrity concerns against the burden of the Stark Law's billing and claims submission prohibitions. The initiatives are aimed at reducing regulatory barriers and accelerating the transformation of the healthcare system into one that better pays for value and promotes care coordination.[4,6,7]

PROPOSED CHANGES

The changes are part of the larger effort by HHS (of which CMS is part) to modernize and clarify fraud and abuse laws as part of the Regulatory Sprint to Coordinated Care initiative and CMS's Patients over Paperwork initiative.[4,7] The aim of the Regulatory Sprint program is to remove potential regulatory barriers to care coordination and value-based care under certain federal healthcare laws, including the AKBS and Stark Law.

CMS proposed a few new and revised exceptions to the Stark Law, which are summarized in Table 1. Additionally, the proposed rule seeks to clarify several of the definitions regarding the "Big Three" requirements included in most Stark Law exceptions for compensation agreements: fair market value (FMV) commercial reasonableness, and the volume or value of referrals standard.

Fair Market Value

The proposed revision of the FMV definition seeks to clarify previous definitions and guidance on FMV and separate the term and definition from other intertwined terms: general market value and the volume or value standard.

Historically, the Stark Law has defined FMV generally (with additional modifications of the definition as applies to equipment leases and office space leases), and intertwined the term with the volume or value standard and the term *general market value*.[9] CMS proposes to provide three separate FMV definitions: (1) generally; (2) for the rental of equipment; and (3) for the rental of office space.[7] However, the agency emphasizes that "the proposed structure of the definition merely reorganizes for clarity, but does not significantly differ from the [previous] statutory language."[7]

CMS clarified that the volume or value standard is "separate and distinct" from fair market value requirements.[7] Thus, CMS no longer believes it necessary to include the volume or value language as it appears in connection to the FMV definition.[7]

Further, CMS provided guidance on the difference between the terms *fair market value* and *general market value* and recognized plausible scenarios wherein a physician may be paid higher than the industry mean, and require a deviation from industry normative benchmark data to account for the specific facts and circumstances related to a given transaction.

CMS provided a hypothetical wherein a hospital seeks to employ an orthopedic surgeon. Industry salary surveys indicate an appropriate annual salary of $450,000 in that locale, but the physician is one of the top orthopedic surgeons in the United States and is in high demand by professional athletes.[7] Consequently, CMS posits that the hospital

Table 1. Proposed New Exceptions to the Stark Law

Exception	Proposal	Purpose
Value-Based Arrangements	Provides several new definitions, including for value-based activity (VBA), value-based enterprise (VBE), value-based purpose, VBE participant, and target patient population. The exceptions would apply only to compensation arrangements, but would apply to all patients, not just Medicare beneficiaries.	To present lower (and fewer) regulatory hurdles for providers seeking to pursue legitimate VBAs that are intended to coordinate care, improve the quality of care, and lower costs for patients. The rule keeps in place some traditional protections against overutilization and associated harms.
Limited Remuneration to a Physician	Allows for limited remuneration to a physician for items or services provided by the physician on an "infrequent or short-term basis," in an aggregate amount not exceeding $3,500 per calendar year (as adjusted by inflation) if: 1. The compensation is not determined in any manner that considers the volume or value of referrals or other business generated by the physician; 2. The compensation does not exceed the fair market value of the items or services; 3. The arrangement is commercially reasonable; and, 4. Arrangements for the rental or use of office space or equipment do not violate the prohibitions on per- click and percentage-based compensation formulas; remuneration does not need to be set in advance, and the arrangement does not need to be set forth in writing in order to comply with this exception.	To provide some flexibility to providers undertaking non-abusive business practices, in recognition that the safeguards contained in such a limited arrangement would pose little to no risk of program or payment abuse.
Cybersecurity Technology and Related Services	Addresses donations of cybersecurity technology and related services that are "necessary to implement, maintain, or reestablish security." For the exception to apply, a number of conditions must be met, including: (1) that the volume or value of referrals not be considered; and (2) the receipt of such technology may not be a condition of doing business with the donor.	To address the growing threat of cyberattacks on data systems and health records; allowing for the donation of cybersecurity hardware, but only if that hardware was determined to be "reasonably necessary" based on the donor's risk assessments of its organization, as well as of the potential recipient.
Group Practice Requirements	Clarifies the following standards and definitions for the Group Practices exception to lower the barriers to qualifying as a "group practice": 1. Volume or Value of Referrals Standard; 2. Profit shares and productivity bonuses (loosening the Volume or Value of Referrals Standard restriction); and, 3. Overall profits.	To explicate various requirements within the Group Practice exception to decrease barriers for providers seeking to comply with the rules for qualifying as a group practice.
Period of Disallowance	Removes the rules related to the period of disallowance, defined as "the period of time during which a physician may not make referrals for DHS to an entity and the entity may not bill Medicare for the referred DHS when a financial relationship between the parties failed to satisfy the requirements of any applicable exception."	To strike rules that CMS now believes to be "overly prescriptive and impractical," as it believes that such analysis should be conducted on a case-by-case basis to account for the facts and circumstances related to the relationship at issue.
Financial Relationship	Revises the definition of a financial relationship to: 1. Exclude titular ownership or investment interests (wherein financial benefits from interest(s) are not received) 2. Exclude any interests arising through participation in an Employee Stock Ownership Program (ESOP).	To provide greater flexibility and certainty for those operating in states with corporate practice of medicine prohibitions.

(Table 1 continues next page)

would be justified in compensating the physician significantly more than the *general market value*, i.e., $450,000 per year, based on the physician's skill set.

Commercial Reasonableness

CMS proposed two alternative definitions for the commercial reasonableness standard, as follows:

1. "[T]he particular arrangement furthers a legitimate business purpose of the parties and is on similar terms and conditions as like arrangements"; or,
2. "[T]he arrangement makes commercial sense and is entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty."[7]

Table 1. Proposed New Exceptions to the Stark Law *(continued)*

Exception	Proposal	Purpose
Compensation and Ownership or Investment Interests	Revises the writing and signature requirements of compensation arrangements such that they may be satisfied if: 1. The arrangement fully complies with another exception except for the writing/signature factor; and 2. The writing/signature is obtained within 90 days of the date of noncompliance.	To recognize that some financial arrangements are fully compliant with the Stark Law, even if they are not set forth in writing and/or signed, and that there are circumstances that require the parties to begin performance prior to the agreed-upon provisions being reduced to writing.
"De-Coupling" From the AKBS	Removes from Stark Law exceptions the requirement that the arrangement not violate the AKBS.	To remove a superfluous requirement, as CMS is "unaware of any instances of noncompliance with the [Stark Law that] that turned solely on an under- lying violation of the [AKBS]."
Price Transparency	Solicits comments on: 1. The availability of pricing information and out-of- pocket costs to patients; 2. Whether to require cost-of-care information at the point of a referral for a healthcare item or service provided to patients; 3. The burden of requiring the provision of such information; and, 4. Whether such requirements should be applied to value- based exceptions.	To accelerate CMS's move toward its larger priority goals, i.e., price transparency aimed at lowering the growth rate of healthcare costs and enhancing patient choice.

Significantly, CMS unequivocally noted that an arrangement may be *commercially reasonable* "*even if it does not result in profit for one or more of the parties*"[7] This is a particularly important development for employed physicians whose specialty may result in a financial loss for the hospital.

This "profitability" caveat may make hospital employment of (or alignment with) certain physician specialists less regulated and benefit patients with service lines and illnesses that are unprofitable for hospitals.

For example, psychiatric and burn units are hospital service lines that often operate at a loss; further, hospitals have licensure and regulatory obligations, such as the Emergency Medical Treatment and Labor Act, that require them to contract with certain physician specialists, regardless whether the volume of services performed by the specialist will be sufficient to render the physician profitable.[7] This "profitability" caveat may make hospital employment of (or alignment with) certain physician specialists less regulated and benefit patients with service lines and illnesses that are unprofitable for hospitals.

Volume or Value of Referrals Standard

CMS proposed four bright-line objective rules for determining whether a compensation arrangement considers the volume or value of referrals or other business generated between the parties, so as to clarify the requirement.[7]

Many Stark Law exceptions require that the compensation arrangement at issue "not [be] determined in a manner that takes into account the volume or value of referrals by the physician . . . [or be] determined in a manner that takes into account other business generated between the parties."[7] In response to commentator concerns, CMS proposed mathematical calculations that will provide objective tests for determining whether a given compensation methodology violates this standard.[7]

IMPLICATIONS FOR AKBS

Physicians and health systems also want CMS to decouple the Stark Law from the AKBS by eliminating regulatory exceptions to Stark that link and forbid any financial arrangements from violating the AKBS.

Physician groups argue that the two laws should not be tied together as they are different with respect to who can be prosecuted, safe harbors/exceptions, intent standards, penalties, and enforcement mechanisms. HHS has proposed changes to the AKBS and the Beneficiary Inducement Civil Monetary Penalties Law (the Beneficiary Inducement Statute) through the OIG. HHS collaborated with the OIG by issuing a request for information to determine how Stark Laws could be modified to fit with the

value-based era but still protect existing federal health programs and patients.

EFFORTS TO PROMOTE PRICE TRANSPARENCY

CMS did not make any specific proposals related to price transparency, but instead used the proposed rule to solicit comments as to the pursuit of the Trump Administration's price transparency objectives and whether to require cost-of-care information at the point of a referral for a healthcare item or service provided to patients.

The idea of requiring cost-of-care information is part of CMS's larger priority goal of price transparency aimed at lowering the rate of growth in healthcare costs and giving patients a better understanding of healthcare costs before embarking on a referral.

IMPLICATIONS FOR EMPLOYMENT MODELS

Proposed changes in the Stark exceptions are predicated upon the idea that these changes will somehow speed up the growth of value-based programs. Some argue that unless clinical processes are accelerated, realistic savings targets issued, and more efficient care models rolled out, these changes may not be enough to ease regulatory burdens on physicians.

In an era of increasing employment of physicians by health systems, although they can be more flexible if within an accountable care organization where they can share quality data, true alignment may not be possible with existing Stark and AKBS laws.

First, the new exceptions related to value-based arrangements likely would reduce burdens for physicians and other providers to align to provide care coordination and other value-based measures without fear of violating the "volume or value of referrals" prohibition. Note that any value-based arrangements must satisfy crucial and specifically defined elements within the new exceptions, including value-based activity, value-based arrangement, and value-based enterprise (*see Table 1*). These exceptions may pave the way for private advanced payment models that were previously considered risky arrangements by payers, hospitals, and physician medical groups.

Second, a proposed exception seeks to provide flexibility to business practices and arrangements CMS finds to be "non-abusive." The Stark Law currently allows "non-monetary compensation" of $416 per year if it is not solicited by a physician and does not take into account the value or volume of referrals by the physician.[7,10] Additionally, the law permits $35 per instance to medical staff for non-cash items or services, such as trinkets given out on Doctors Day.[11]

A new exception will allow limited remuneration from the employing institution to a physician, "even in the absence of documentation regarding the arrangement and where the amount of or a formula for calculating the remuneration is not set in advance of the provision of items or services."[7] This would be allowed if certain conditions are met and only if the remuneration does not exceed $3,500 per year.[7] Some examples to which this exception may apply, according to CMS, include:[7]

1. A hospital and physician agree to an arrangement wherein the physician will provide call coverage services, but the arrangement was not documented (the first $3,500 would be covered under this exception, but any subsequent services/payments would need to fit under another Stark exception);
2. A hospital and physician have a call coverage arrangement that fits within another Stark exception, but the hospital subsequently engages the physician to provide sporadic supervision services, which was not documented (so long as the amount paid for the supervision services is less than $3,500 for the year); and,
3. A hospital and physician have a call coverage arrangement that fits within another Stark exception, but the hospital subsequently engages the physician to *both* provide sporadic supervision services and perform occasional EKG interpretations, neither of which arrangement was documented (so long as the amount paid for *both* the supervision services *and* the EKG interpretations is less than $3,500 for the year).

Third, specific to group physician practices, CMS proposes changes to multiple standards and definitions to lower barriers for physicians seeking to qualify as a "group practice" as set forth in Table 1.

Of note, CMS proposes changing the rules regarding profit shares and productivity bonuses so that going forward, a group practice could directly distribute profits emanating from a physician's participation in a value-based enterprise (including profits from the physician's referrals) to that physician, and that distribution would be deemed to not directly take into account the volume or value of the physician's referrals.[7]

VALUATION IMPACT ON PHYSICIAN PRACTICES

Perhaps the most revealing takeaway from the proposed rule for physicians stems from CMS's acknowledgment that not all physicians or compensation arrangements are the same, and that compensation arrangements may have qualitative benefits that outweigh quantitative costs, *i.e.*, profitability. The significance of this recognition is critical — it means that hospitals may be more willing to purchase physician practices, even if the purchase results in a "book financial loss" for the hospital.

CMS's proposals recognize that an arrangement may have inherently *subjective*, *qualitative* elements. For example, there are plausible scenarios that may require a valuation professional to deviate from industry normative benchmark data to account for the specific facts and circumstances related to a given transaction. This further demonstrates the need for valuation professionals in the healthcare industry who use an evidence-driven methodology that includes both *qualitative* and *quantitative* assessments of the specific facts and circumstances related to the transaction; document their consideration of these facts and circumstances; and, articulate their ultimate applicability to the transaction in support of their opinion.

DOWNSIDES TO THE PROPOSED CHANGES

In 2018, three large settlements with DOJ were reached for physician remuneration in exchange for patient referrals ($260 million),[12] free or discounted physician office space in exchange for patient referrals ($84.5 million),[13] and excessive physician compensation above fair market value in exchange for referrals ($24 million).[14] Proposed relaxation of Stark rules have led to concern that changes in these healthcare relationships may lead to more fraud, patient harm, and anticompetitive behavior by large health systems and hospitals.[7]

FINALIZATION

The rules were published in the Federal Register on October 17, 2019, and all comments on the proposed rule were due 75 days from the date of publication, *i.e.,* by December 31, 2019. Upon the end of the comment period, CMS has no official timeline by which it must publish the Final Rule.

CONCLUSIONS

CMS's proposed rule changes clearly aim to remedy the current Catch-22 situation that physicians and providers face, making it easier for them to provide value-based care without running afoul of the Stark Law. CMS has made significant strides in attempting to reduce the burden of compliance while also maintaining strong safeguards against fraud and abuse.

Medical groups are concerned about the proposed changes because they believe the fundamental issue of unfairness to physicians has not been addressed and that any changes will simply add more layers to existing law. Ultimately, if major structural modifications are needed, Congress will need to step in and deliver further alterations to existing law.[15]

REFERENCES

1. Satiani B. Exceptions to the Stark Law: Practical considerations for surgeons. *Plastic & Reconstructive Surgery*. March 2006;117(3): 1012–1022.
2. Limitation on Certain Physician Referrals. 42 U.S.C. § 1395nn.
3. Advis Healthcare Survey. Advis; https://advis.com/advis-in-the-news/advis-healthcare-survey-may2019. Accessed November 11, 2019.
4. U.S. Department of Health & Human Services. HHS proposes Stark Law and Anti-Kickback Statute reforms to support value-based and coordinated care. U.S. Department of Health & Human Services; https://www.hhs.gov/about/news/2019/10/09/hhs-proposes-stark-law-anti-kickback-statute-reforms.html. Accessed October 25, 2019.
5. For more information, see: Cimasi RJ, Zigrang, TA, Bailey-Wheaton JL, Chwarzinski JR. Beyond FMV: commercial reasonableness of physician compensation post-MACRA. *Business Valuation Review*. 2018; 37(1):20–46.
6. Centers for Medicare & Medicaid Services. Modernizing and clarifying the Physician Self-Referral Regulations Proposed Rule. Centers for Medicare & Medicaid Services; https://www.cms.gov/newsroom/fact-sheets/modernizing-and-clarifying-physician-self-referral-regulations-proposed-rule. Accessed October 22, 2019.
7. Medicare program: modernizing and clarifying the physician self-referral regulations. *Federal Register*. October 17, 2019;84(201):55777, 55788- 55790, 55791, 55793-55794, 55797, 55799-55804, 55808-55809, 55811- 55815, 55828-55829, 55828-55830, 55835, 55840.
8. Office of Inspector General. Notice of Proposed Rulemaking OIG-0936- AA10-P: Fact Sheet. Office of Inspector General; https://oig.hhs.gov/authorities/docs/2019/CoordinatedCare_FactSheet_October2019.pdf. Accessed October 22, 2019.
9. Definitions. 42 C.F.R. § 411.351.
10. Exceptions to the referral prohibition related to compensation arrangements. 42 C.F.R. § 411.357(k).
11. Wynne B, Pahner K, LaRosa J. Proposed Stark Law, anti-kickback reforms aim to facilitate value-based care. Health Affairs Blog; https://www.healthaffairs.org/do/10.1377/hblog20191014.13154/full/. Accessed November 13, 2019.
12. U.S. Department of Justice. Hospital chain will pay over $260 million to resolve false billing and kickback allegations: one subsidiary agrees to plead guilty. U.S. Department of Justice; https://www.justice.gov/opa/pr/hospital-chain-will-pay-over-260-million-resolve-false-billing-and-kickback-allegations-one. Accessed December 12, 2019.
13. U.S. Department of Justice. Detroit area hospital system to pay $84.5 million to settle False Claims Act allegations arising from improper payments to referring physicians. U.S. Department of Justice; https://www.justice.gov/opa/pr/detroit-area-hospital-system-pay-845-million-settle-false-claims-act-allegations-arising. Accessed December 12, 2019.
14. U.S. Department of Justice. Kalispell Regional Healthcare system to pay $24 million to settle False Claims Act allegations. U.S. Department of Justice; https://www.justice.gov/opa/pr/kalispell-regional-healthcare-system-pay-24-million-settle-false-claims-act-allegations. Accessed December 12, 2019.
15. Committee on Finance, United States Senate. Examining the Stark Law: current issues and opportunities. Committee on Finance, United States Senate. https://www.govinfo.gov/content/pkg/CHRG-114shrg26440/html/CHRG-114shrg26440.htm. Accessed December 12, 2019.

Medical Informed Choice: Understanding the Element of Time to Meet the Standard of Care for Valid Informed Consent

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Medical informed choice is essential for physicians meeting their fiduciary duty when proposing medical and surgical actions, and necessary for a patient to consent or cull the outlined therapeutic approaches. Informed choice, as part of a shared decision-making model, allows a wide-ranging give-and-take of ideas between the patient and physician. This sharing of ideas produces a partnership for decision-making and a shared responsibility for medical and surgical outcomes. Informed choice is indispensible to the patient education process that meets the desired outcome of any covenant—an offer of and acceptance of the proposed treatment. The covenant anchors a true patient–physician partnership with parity and equality in decision-making and medical/surgical outcomes. Medical informed choice flows from ethical and legal principles necessary to meet the acknowledged standard of care. This is codified by statute and fortified in general common law. This espouses a fiduciary relationship where the patient and physician understand and accede to the degree of autonomy the patient requests.

KEY WORDS: Patient–physician relationship; informed choice; informed consent; shared decision-making; liability.

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In today's medical marketplace, physicians are working at a feverish pace to meet the demands of the business model decreed by their employer. That business model has physicians seeing more patients in less time. The operative word is "time," because quality work requires time and meeting the medical professional standard of care also requires time.

Time is the dependent variable in the informed choice function of meeting the standard of care.

The medical standard of care is the ethical and legal duty of a professional to exercise the level of care, diligence, and skill prescribed in the "code of practice" of her profession, or as other professionals in the same discipline would in the same or similar circumstances. This is the standard physicians face as they practice in a fast-paced medical marketplace where reimbursements are shrinking and increased patient volume is the prevailing mechanism to increase revenues. That creates a dilemma for physicians, because that faster pace means less time per patient, and less time means less deliberation and diligence in taking a medical history, performing a physical examination, developing a differential diagnosis, and educating patients about the elements of medical choice so they can then make an informed, knowledgeable, and voluntary decision about the healthcare they want or don't want. That shared, informed decision-making process is time dependent.

Time is the dependent variable in the informed choice function of meeting the standard of care. The new healthcare business equations are creating a shrinking time variable. This disconnect between patient care and business models of medicine puts physicians at risk for failing to meet the threshold for the informed consent standard of care. This failure may place physicians at risk for allegations of negligence. The time disconnect weighs heavily

on physicians' minds, because they constantly face the potential of alleged liability. Shrinking time with patients can never lead to increased quality or a trusting physician–patient relationship.

True informed choice results in a meeting of the elements of the standard of care and limits any potential for alleged negligence

Physicians have a moral, legal, and ethical responsibility to understand medical informed choice. This responsibility emanates from the fiduciary duty physicians owe patients. Furthermore, true informed choice results in a meeting of the elements of the standard of care and limits any potential for alleged negligence.[1]

This article addresses the patient and physician criteria for medical choice to be valid, the exceptions to obtaining medical informed choice, the ethical and legal foundations to medical informed choice, the different standards that are adequate to meet the standard of care, and the fact that no single paradigm fits all patient situations.

MEDICAL INFORMED CHOICE: PATIENT CRITERIA FOR VALID INFORMED CHOICE

What considerations define whether patients are capable of participating in the informed choice/shared decision-making process? That determination is based on deciding whether the patient is mentally capable and has decision-making capability. *Capacity* is a person's ability to make an informed decision. Succinctly stated, the patient must be able to comprehend the information presented and the associated potential benefits, risks, and alternative choices in their medical care.

Every part of a patient's decision must be intentional. Family members, other interested parties, or healthcare professionals should not affect the patient's decisions. It is imperative that medications or life stressors not compromise patients involved in informed choice/shared decision-making. A patient with intact cognitive capacity and intact decision-making capacity may reverse a medical/surgical decision at any time. The competent patient may reject any proposed treatment, despite the consequences of that decision.

PHYSICIAN CRITERIA FOR INFORMED CHOICE TO BE VALID

What subjects must a physician share with a patient to meet the threshold for valid informed choice/shared decision-making? Physicians must divulge to patients the diagnosis; the nature and purpose of the proposed treatment or procedure; reasonable available alternative approaches; relevant risks, benefits, and uncertainties of each alternative; and the risks and benefits of choosing not to have a treatment or procedure.[1] Additionally, physicians should take the time to ensure that the patient understands the diagnosis, treatment choices, and the risks and benefits of treatment versus no treatment.

THE EXCEPTIONS TO OBTAINING INFORMED CHOICE

Exceptions to medical informed choice occur when physicians are confronted with medical emergencies that would result in permanent injury or death without immediate intervention. In these unique circumstances, even though the patient's preferences and desires are unknown, informed consent is presumed.[2]

Additional exceptions to informed choice include a patient foregoing a right of informed choice and therapeutic privilege. By signing a waiver, a patient freely and willfully relinquishes a legal right. Patients may elect to sign a medical waiver when considering medical informed choice/shared decision-making. The patient may choose a surrogate decision-maker or adopt the physician as the decision-maker. Caution should be abundant when using a waiver for informed choice. Legally, waivers can be a slippery slope, and it is in the best interest of physicians to involve the risk management or legal team to develop an exhaustive legal covenant in such a situation.[3]

The *therapeutic privilege* is a doctrine allowing the physician to withhold information if disclosure of the knowledge would actually harm the patient. The therapeutic privilege should be used on rare occasion, because it is dicey, both ethically and legally. State precedent governs the interpretation of the therapeutic privilege, and the court's analysis is variable from state to state. In these circumstances, it is imperative for the physician to document in detail the rationale for invoking the therapeutic privilege, and the ethics and risk management teams should be involved.[3]

ETHICS AND INFORMED CHOICE: BENEFICENCE AND NON-MALEFICENCE

Beneficence (doing good) and non-maleficence (do not harm) underlie the physician's moral imperative. This moral imperative infers there are times or circumstances when partial disclosure or no disclosures are concordant with meeting the standard of care and fiduciary duties. This flows from the fact that some patients are emotionally incapable of handling discussions that entail life-and-death issues or consequences when they are in a regressed

state of mind. This permits physicians the opportunity to modify the medical information they deliver to patients in an empathic manner that meets the moral imperative of beneficence and non-maleficence. The ultimate goal of informed choice should be respect for a patient's autonomy combined with tactful application of beneficence and non-maleficence.[4] This requires ongoing conversations over time and a trusting partnership.

THE LEGAL FOUNDATION FOR INFORMED CHOICE

The legal basis for mandating informed choice dates back to the 1700s. In *Slater v Baker and Stapleton* in 1767, the court established that physicians should obtain consent from patients before surgery and could be held legally liable if they proceeded without informed consent.

In *Schloendorff v Society of New York Hospital* in 1914, a physician removed a tumor from a patient who had consented only to an examination and had refused an operation. Justice Cardozo wrote: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Schloendorff established the necessity of voluntary agreement for each specific proposed procedure (*Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129-30).

The phrase "informed consent" was born in the California Court of Appeals case *Salgo v Leland Stanford Jr. University Board of Trusteees.* The court held that a physician could be held liable for failing to provide facts about a proposed treatment that are necessary for a patient to make an informed decision. Additionally, the decision stated that physicians must exercise discretion when deciding what risks to disclose in order to protect a patient's well-being *(Salgo v Leland Stanford Jr. University Board of Trusteees.* Pacific Reporter, 2d Series 1957; 317: 170-182). This decision failed to delineate any clear limits on what must be disclosed. The California Supreme Court articulated this uncertainty: "One cannot know with certainty which medical consent is valid until a lawsuit is filed and resolved" (*Moore v Regents of the University of California*, 51 Cal 3d D20 165 793. P 2d 479 291 Cal Rptr. note 41 (1990)).

There does not appear to be a standard of disclosure to which physicians can adhere to avoid liability with certainty.[1]

WHAT DOES THE COURT REVIEW WHEN PRESENTED WITH AN INFORMED CONSENT CASE?

When a case advances to court, appropriate documentation of the informed choice process can be used as a defense that the physician properly informed a patient about a treatment or procedure. That documentation should be stored in the medical record. Physicians should document the details of the discussion and the time devoted to educating the patient and answering the patient's questions.

Informed consent forms may be helpful to satisfy legal requirements and make documentation more efficient, but they are not an acceptable replacement for time spent with the patient. Consent forms used to replace physician time negatively impact the physician–patient relationship. The use of informed consent forms has evolved into a legalistic process attempting to limit liability rather than facilitating comprehension and understanding of the treatment or proposed procedure. There is a feeling that the focus of physicians is on risk communication and not on informed medical decision-making.

Sensibly, if more time were spent educating and building a trusting partnership with the patient, there would be less need to have consent forms and a lower likelihood of ending up in court facing an allegation of negligent informed consent. Ultimately, upon review of the medical record the court evaluates the time dedicated to information sharing and shared decision-making between the physician and the patient to determine whether a physician met the standard of care for informed consent.

DEFINING THE STANDARDS OF DISCLOSURE

Two dominant approaches, the "professional" standard and the "materiality" standard, define the standard of disclosure of information by which a physician's duty to the patient is measured[1] (*Madare v Oschner Foundation Hospital*, 505 So 2d 146 (La Ct App 1987)).

The professional standard requires the physician to disclose information that other physicians possessing the same skills and practicing in the same or a similar community disclose in a similar situation[1] (Canterbury v Spence, 446 F2d 772 (CADC 1972)).

The materiality, or "prudent patient," approach allows the jury to decide whether other information would have been considered important by a reasonable patient in making a decision and therefore requiring disclosure[1] (*Cowman v Hornaday*, 329, NW 2d 422 (Iowa 1983)).

The courts recognize situations when a physician's nondisclosure will be excused, including cases of the patient's mental incompetence, medical emergencies, and the therapeutic privilege exception.[1,5] If a patient is incompetent to make a reasoned decision, then disclosure to the patient might not be required[1] (*Banks v Wittenberg*, 266 NW 2d 788 82 Mich App 274 (Mich App 1978)).

The physician also can withhold information under the therapeutic privilege if disclosure would interfere with treatment or would adversely affect the condition or recovery of the patient.[1,6] The emergency exception to disclosure

applies in situations where attempting to secure consent would delay necessary and proper treatment[1] *(Shafford v Louisiana State University*, 448 So 2d 852 (La Ct App 1984)).

Last, physicians need not disclose risks of which the patient is already aware, or risks that are commonly known[1] *(Kissinger v Lofgren*, 836 F 2d 678 (CA 1 [Mass] 1987)).

Individual state law and court decisions determine which approaches and exceptions apply in an individual physician's practice.

In order to facilitate true informed consent, some states have initiated shared decision-making legislation. Shared decision-making requires intense education of the patient. Pamphlets, videos, and a vast array of telecommunication infomercials often are provided to patients, allowing them to more fully understand the proposed treatment or procedure and then incorporate their own values and preferences into the decision-making process. Providing additional written material; audiovisual, multimedia and test and feedback techniques; in addition to adequate time for education and shared decision-making all improve patient comprehension, especially regarding risks and general knowledge about the procedure.

CONCLUSION

There is no single prototype that meets the elements of the standard of care for informed consent and applies to all patients. Medical informed consent is essential to a true patient–physician relationship. Patients need to participate in the informed consent process to understand the risk–benefit relationship for the proposed treatment strategy. This understanding is essential because patients often are psychologically regressed secondary to the realization that they are confronting a life-preserving procedure that carries significant risk.

Physicians need to participate in the informed consent process to provide patients with the best treatment available by sharing decision-making and limiting any potential for liability. Medical ethics, common law, and, in many states, codified statutory law mandate the informed consent process. Physicians would be prudent to be knowledgeable in these areas of medical ethics, common law, and statutory law.

Physicians would be judicious also to understand that the consent process is vital to the physician–patient relationship and that no single archetype can define the ethical, medical, and legal approach a physician should undertake to achieve informed consent. The process should be individualized within the boundaries of the patient's desires for self-determination, thus reflecting true patient autonomy.

The overarching principle is meeting the elements of true informed choice/consent, and informed consent requires time. Despite the evolving business model of medicine, physicians must demand abundant time to educate, counsel, and share decisions with patients. The constellation of abundant time, true partnership, and sharing in decisions is the panacea to preventing allegations of negligence.

Time cannot and must not be shorted. Adjuncts such as pamphlets and videos are helpful, but cannot replace a physician taking time with a patient. All true relationships are time dependent. Meaningful shared decisions require time, and taking that time will result in better clinical decisions and outcomes and less potential for liability.

REFERENCES

1. Paterick TJ, Carson GV, Allen MC, Paterick T. Medical informed consent: general considerations for physicians. *Mayo Clin Proc.* 2008;83:313-319.
2. Arard A, Herlitz J, Hermeren G. Obtaining informed consent from patients in the early phase of acute myocardial infarction: physician experiences and attitudes (letter). *Heart.* 2004;90:208-210.
3. Klove C, DiBoise SJ, Pang B, Yarbrough C. Informed consent: ethical and legal aspects. *Thorac Surg Clin.* 2005;15:213-219.
4. Steinberg A. Disclosure of information and informed consent: ethical and practical considerations. *J Child Neurol.* 2009;24:1568-1571.
5. Meisel A. The "exceptions" to the informed consent doctrine: striking a balance between competing values in medical decision-making. *Wis L Rev.* 1979;1979(2):413-488.
6. Carnerie F. Crisis and informed consent: analysis of a law-medicine malocclusion. *Am J Law Med.* 1987;12(1):55-97.

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Dennis Thornton*

This article explains the importance of the lease renewal process. We pull back the curtain to reveal what motivates a landlord, which will prepare tenants to capitalize on a successful lease renewal.

KEY WORDS: Lease; lease renewal; lease renegotiation; healthcare; cash flow; real estate; landlord; tenant.

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Although healthcare practice tenants may feel good about having a renewal option in their lease, the truth is that such an option typically is drafted to benefit the landlord much more than the tenant. Tenants often can obtain much better terms if they understand the landlord's intent behind a renewal option and know how to execute a specific game plan to achieve terms in their favor.

Property owners don't want tenants to know that even if the tenant has a renewal option, they usually can negotiate a better deal if they decline their renewal option and renegotiate. With proper representation, tenants can achieve significantly better terms than what is offered by most lease renewal options. Additionally, most tenants don't know there is a margin in every deal to realize concessions beyond those that are initially proposed.

Most practices handle their lease renewals without doing research, talking to a real estate advisor, or negotiating in any way. Instead, they blindly exercise the lease renewal option and assume the terms are "fair" or "good enough." Many healthcare providers take this approach because they are "too busy" or do not know whom to contact to help them with the process. Automatically exercising the lease renewal option represents a lost opportunity for the practice to recapture tens to hundreds of thousands of dollars in excess expenses over the length of a standard lease.

THE PLAYING FIELD IS NOT LEVEL

The terms of a renewal option rarely favor the tenant. Landlords work hard to protect themselves by ensuring the lease rate of a renewal option is higher than what they would charge a new tenant for a vacant space. When an existing tenant agrees to renewal terms without negotiating properly, that tenant leaves a substantial amount of money and concessions on the table. The bottom line is that most tenants are starting their negotiation on an unlevel playing field. The results of a poorly negotiated lease can dramatically impact a practice's profitability.

ABOVE-MARKET LEASE RATES

The vast majority of leases include an annual increase clause that raises the rental price each year. Those annual increases typically outpace inflation, creating a lease rate that is almost always well above the current market value at the end of a lease term. If the landlord had to release the space to a new tenant, it would usually be at a lease rate that is lower than the current lease rate and renewal option terms. This presents another compelling reason to avoid signing off on most lease renewal options.

THE IMPORTANCE OF A RENEWAL FOR THE LANDLORD

Most renewals are rich deals for property owners. They can make much higher margins on a renewal with an existing tenant than with a new lease by keeping rates above market and offering minimal concessions to encourage the tenant to sign the renewal. In addition, the landlord saves money by avoiding several costs that would arise if the tenant decided to relocate and leave the space, including the following:

- **Vacancy and rent collections:** It is not uncommon for a vacated space to remain that way for a year or longer, even in a tight market. Not only is the landlord not collecting any rent for the entire year before the new prospective tenant comes along, but when you factor in the new tenant's negotiation period, build-out period, and free rent period, it could be a total of 18 to 24 months before the landlord sees another check for the space.

- **Advertised rates:** To be competitive, a property can't be advertised at inflated rates. Landlords may need to market their spaces at rates that are considerably lower than what many of their tenants are paying, and they are banking on the current tenants being none the wiser.
- **Tenant improvement allowance:** If the current tenant leaves, it is likely that the space will have to be refreshed or redone completely. It is extremely rare for the existing build-out to be a perfect fit for the next occupant, which means a landlord may have to invest tens or hundreds of thousands of dollars to accommodate the new use.
- **Free rent:** New tenants often receive a free rent period, in addition to the no-rent build-out period. Landlords may give three months or more in free rent on longer term leases.

CONCLUSION

These expenses add up, which is why a landlord is motivated to find savings by renewing a lease with an existing tenant. When a tenant exercises their renewal option without comparing their terms to what a new tenant would receive or what they could achieve at a competing property, the landlord pockets these savings instead of passing them on to the current tenant. The difference between these savings and what a landlord actually offers a renewing tenant can be astounding. It is not uncommon for a landlord to save well over $100,000 by doing a renewal instead of finding a new tenant and investing all the additional expenses into the deal.

If approached properly, it is possible to save tens to hundreds of thousands of dollars on your lease renewal.

The typical concessions offered to the tenant in most renewal scenarios are a mere fraction of the savings realized by the landlord when a tenant renews. Knowing this, it is imperative to hire a healthcare real estate advisor to exclusively represent your interests and to develop a customized strategy to procure your next lease. This will ensure you are getting the best possible terms on your lease renewal and will tip the negotiation scales back in your favor. If approached properly, it is possible to save tens to hundreds of thousands of dollars on your lease renewal. Alternatively, if you simply accept the renewal option terms blindly, the same potential savings and concessions can result in dramatic losses and added expenses that can be avoided.

Help your practice avoid this common pitfall by understanding how much is really at stake during your next lease renewal, and then be prepared to capitalize.

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Pinball Wizard or Bowling Alley Marketing

Neil Baum, MD*

The landscape and methods of healthcare have changed, and the old, traditional medical marketing techniques are no longer going to be effective. This article discusses two approaches—"bowling" and "pinball" marketing.

KEY WORDS: **Marketing; social media; online review sites; reputation management; traditional media; Facebook; YouTube; Google.**

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In the late 1900s and early 2000s, the standard way to create a website was to electronically convert your trifold, colored, patient brochure and put it up on the Internet. This type of website is no longer an effective method of marketing and promoting your practice.

Traditional marketing resembles bowling: a practice uses traditional marketing techniques (the bowling ball) to reach and influence patients (the pins) (Figure 1). Mass media (the bowling alley) function as mediators for marketing content. Medical marketers throw the ball as hard and straight as they can, in the hope that it will hit the target. But the marketing journey isn't a straight line anymore and neither should your marketing be. Marketing today is actually more like a game of pinball (Figure 2).

Social media has changed the picture. Marketing is now more closely aligned with a pinball machine. "Pinball marketing" is an environment in which marketing instruments (the balls) are used to reach patients (bumpers, kickers, and slingshots). In the new pinball environment, patients have much more control than they had in the old bowling alley atmosphere. Empowered patients receive regular messages and actively participate through social media by sharing their experiences with doctors and their practices. The "slingshots" and "bumpers" of social media further increase the unpredictability of the marketing dynamics by multiplying social media episodes and providing the basis for future pinball activities. To continue the pinball metaphor, the pinball machine is our current environment, the balls are marketing instruments, and the audience are the spinners, bumpers, and flipper bats that propel the ball away from the hole that ends the contact with that ball (Figure 2). Unlike bowling, where the "pins" had no power to make an impact, the audience in pinball marketing can actively take part, redirecting the ball or causing it to speed

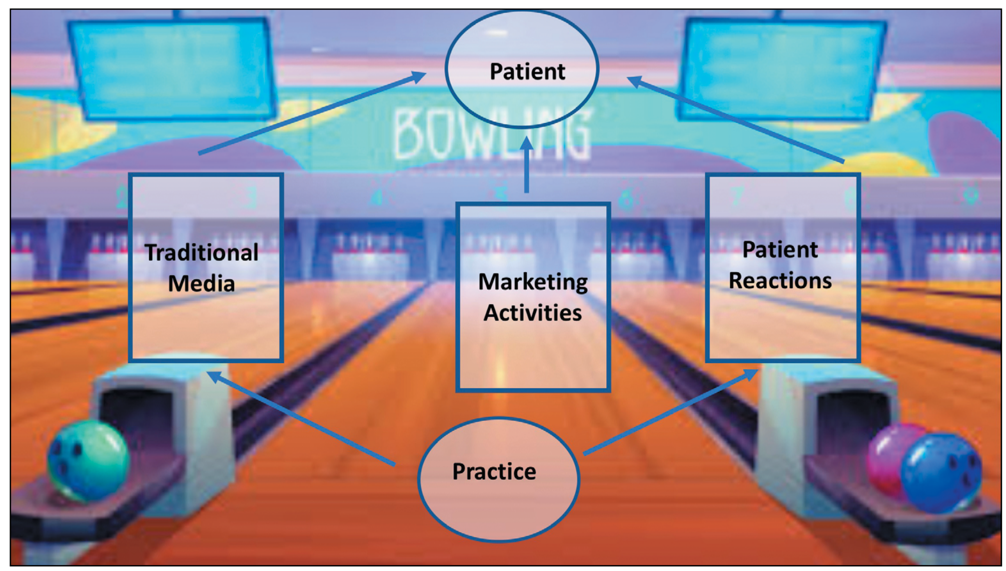

Figure 1. Traditional marketing resembles bowling.

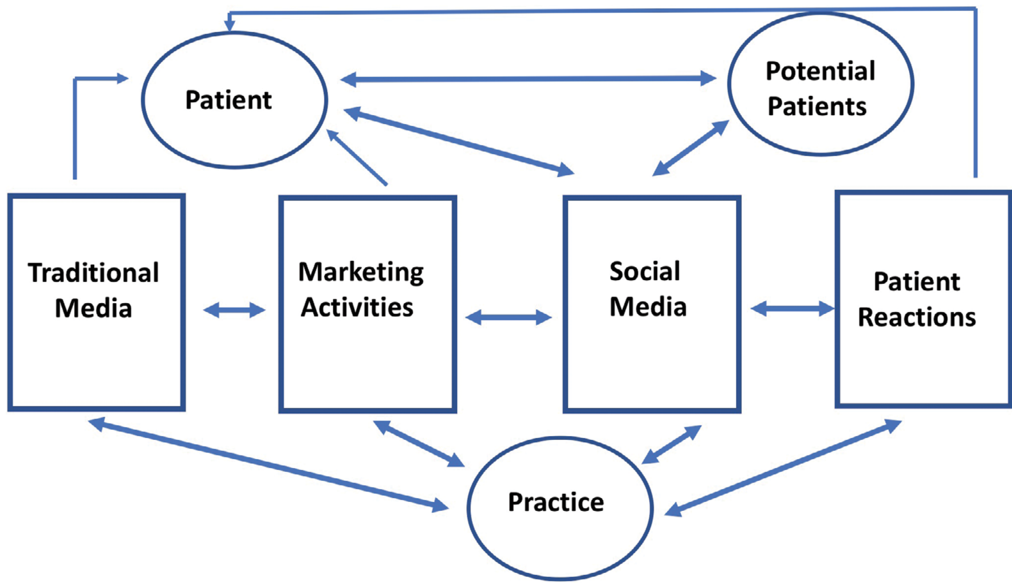

Figure 2. Marketing today is more like a game of pinball.

up, slow down, or even stop. But be careful not to shake the machine too vigorously or you will have the dreaded tilt message and your game will be terminated.

> ***The dramatic growth of social media has affected medical practices in ways we are just beginning to understand.***

Since its introduction in 2006, Facebook has grown exponentially. By 2013, it was one of the top three websites, along with Google and YouTube. One out of seven persons on this planet is an active member of Facebook,[1] in spite of limitations to people under 13 years of age and the fact that it is not accessible in China, the world's most populous country.

This dramatic growth of social media has affected medical practices in ways we are just beginning to understand. This article offers an overview for those physicians and practices interested in digital marketing and how social media has changed the playing field between physicians and both existing and potential new patients.

We have to go where our markets are (e.g., email, Facebook, Twitter) and create relevant content, experiences, and platforms where they can engage with us.

As a marketer you can no longer simply roll a bowling ball and wait for it to hit your target—you must actively take part. You must interact with your existing patient or potential new patients. It is important to test multiple digital media options, run multiple campaigns, and measure those campaigns to see how audiences are responding to your content or your message. It is essential to identify what works and continue that marketing method, and also to find out what doesn't work and delete it from your marketing mix. The days of just having a webpage or a blog and considering that effective marketing are over. You must provide fresh content on a regular basis and you must have multiple social media outlets such as YouTube, Facebook, and Instagram.

Bowling is like playing American baseball or standing over a pot of water and watching it boil. Pinball, on the other hand, is played at high speed; you have to continually monitor and tweak the vast multimedia options, and you must take action based on your findings. But your job doesn't end after you've uploaded a new social media post or issued a new press release—you have to follow its course carefully, measure its impact, and then identify any trend or crisis.

> ***If you don't move fast enough in pinball, you lose—and it's the same with healthcare marketing.***

If you don't move fast enough in pinball, you lose—and it's the same with healthcare marketing. Monitor your audience and be ready to respond to what attracts or deters your audience. There is a world full of potential patients who have access to social media platforms, where they can share both their positive and their negative experiences about a practice's services. Negative comments can quickly escalate into a crisis that threatens the success of the practice.

In this chaotic, interactive world, your marketing approach needs to move from bowling to pinball. This not only will help you recognize the increasing power of the consumer and embrace the cocreation of brand stories, but also will enable you to develop a deeper engagement with your market and your patients. When you see the value of a multichannel campaign and start understanding how each component complements the others, you will start to reach that top score!

If you are not connecting with your patients like a pinball player in this era of social media networking, then you will fail to connect to potential patients who may want to avail themselves of your services.

Your community of potential patients is the lifeblood of your social networking. It's essential to ensure that this community is full of potential patients who are actually interested in what you have to say or the services you wish to offer. You want to target those people in your community who are interested in you and your practice, not the fact that you friended them first and not the fact that you use a certain hashtag in your tweets. Those actions seldom result in new patients. One of the methods you can use to identify those targets is to consider psychographics.[2]

To reach your ideal patients, you must know what or who they value most, where they get their medical education and medical information, and what content appeals to them.

Psychographics focuses on the interests, attitudes, and emotions of a segment of potential patients—exactly the things practices need to understand to best promote their services to the particular segment of the population that the practice wishes to attract. To reach these ideal patients, you must know what or who they value most, where they get their medical education and medical information, and what content appeals to them.

Psychographics is like demographics on steroids. Psychographic information might include your patients' habits, hobbies, health-related experiences, and values. Demographics explain "who" your patient is, whereas psychographics explains "why" they become part of your practice.

Your message must be engaging to anyone who accesses your material. Your social media pipeline must be full of information that highlights the physicians and the practice. For example, if you write an article on your urinary incontinence program, and your title is "The Diagnosis and Treatment of Urinary Incontinence," that probably will not entice readers, even if they have incontinence, to read your article or to make an appointment with your urologic or gynecologic practice. However, a title such as "Urinary Incontinence—You Don't have to Depend on Depends!" is likely to attract readers to drill deeper into your message and perhaps contact your office, ask questions, ask for more information, and, hopefully, make an appointment. You are actually having an electronic conversation with a potential patient and you want to receive a response that starts the conversation. Remember that it's *social* media, and you must be social with it.

Today, in an Internet world and with social media having become ubiquitous, the bowling metaphor no longer fits. Now it's time to play pinball. Now medical practices release a "marketing ball" consisting of the practice brands and brand-building messages, which are then diverted or bounced around and often accelerated by social media "bumpers," which change the offering's course in chaotic ways. After the marketing ball is in play, those who are in charge of marketing and practice promotion attempt to guide the marketing with agile use of the "flippers," but, unfortunately, the ball does not always go where it is intended. Those who receive the marketing message now can respond, provide their opinion, decide to receive or reject the message, or ask for additional information. Also, potential patients can initiate their own discussion by bringing up topics that are important to them and look for the healthcare profession to respond. Marketing in the pinball era involves the player (the practice) launching the ball into play by feeding engaging and useful content into the game area, where it is moved around by those online. Occasionally, it will come back to us via email or through physician review sites that affect our online reputation. At this point, we can use the flippers to interact with patients and potential patients and pass the ball back into the social media sphere.

If our practice does not feed the social media sphere by flipping communications back, the ball will drop through the flippers, and the longer-term, two-way relationship between the patient and the practice will cease to exist.

Bottom Line: Practices have to start a conversation, listen to what the patients want, and then respond in a timely fashion. Medical practices have to learn how to maneuver the pinball in this new environment or the ball will slowly slide down between the flippers and be out of play—meaning the practice won't gain new patients or maintain the loyalty of existing patients.

REFERENCES

1. Hennig-Thurau T, Hofacker CF, Bloching B. Marketing the pinball way: understanding how social media change the generation of value for consumers and companies. *Journal of Interactive Marketing*. 2013;27:237-241.
2. Baum NH. Patient profiling using psychographics: demographics vs. psychographics and why culture matters most. *J Med Pract Manage*. 2020;35:234-236.

Coronavirus and Your Practice Procedures

Debra Cascardo, MA, MPA, CFP*

Coronavirus has made a difference in your practice procedures. You've reorganized your waiting room and check-in procedures to comply with social distancing. Staff are required to wear masks and increased personal protection equipment (PPE). Sanitizing has been brought to a new level. Patients must wear masks and notify you of their arrival before entering the waiting room.

But have you reviewed and updated your Procedures and Policies manual? With the new normal brought on by the outbreak of human coronavirus and the resultant school closings, travel bans, social distancing, community lockdowns, and other concerns throughout the world, it is time to review your office procedures and HIPAA regulations relative to patient rights and public safety.

Understandably, the public, and especially healthcare employees, are concerned about contracting this mysterious, pneumonia-like virus rapidly spreading around the world, because the numbers of confirmed cases spike each day as more people are tested and/or show symptoms. The CDC and local government agencies want to track testing, exposure, recoveries, and deaths to determine where the virus is heading.

At the time of writing this article, the Department of Health and Human Services had declared a public health emergency with respect to coronavirus. Under the public health emergency, covered entities must understand what their obligations are with respect to use and disclosure of protected health information (PHI).

WHAT IS THE HIPAA PUBLIC HEALTH EXEMPTION?

The HIPAA Privacy Rule permits that public health authorities and others who ensure public health and safety be given access to PHI to carry out public health activities. The Privacy Rule also recognizes that public health reports made by covered entities play an important role in identifying threats to individual and public health and safety. As such, the Privacy Rule allows covered entities to disclose PHI without authorization for certain public health purposes.

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Under the HIPAA public health exemption (which applies, among other reasons, when a public health emergency has been declared), covered entities may, without written patient authorization, disclose PHI to public health authorities legally authorized to receive it, for the purposes of preventing or controlling disease, injury, or disability. Disease, injury, and disability prevention and control measures and activities include reporting of disease or injury, and reporting of vital events, such as deaths.

Under the HIPAA public health exemption, a covered entity also may disclose written patient authorization and may disclose PHI to conduct public health surveillance, investigations, or interventions.

Covered entities also may, if directed to do so by a public health authority, disclose PHI to a foreign government agency acting in collaboration with that authority. Covered entities that are public authorities may use and disclose PHI for:

- The purpose of preventing or controlling disease;
- The purpose of preventing or controlling injury; and
- The purpose of preventing or controlling disability.

Disease, injury, and disability prevention and control measures and activities include:

- Reporting of disease or injury;
- Reporting of vital events (i.e., births, deaths); and
- Conducting public health surveillance, investigations, or interventions.

Covered entities also may, if directed to do so by a public health authority, disclose PHI to a foreign government agency acting in collaboration with that authority. Covered entities that are public authorities may use and disclose PHI for:

- The purpose of preventing or controlling disease;
- The purpose of preventing or controlling injury; and
- The purpose of preventing or controlling disability.

WHAT IS A PUBLIC HEALTH AUTHORITY?

The HIPAA Privacy Rule defines a *public health authority* as any of the following that is responsible for public health matters as part of its official mandate:

- An agency or authority of the United States government;
- A state;

- A territory;
- A political subdivision of a state or territory; or
- An Indian tribe.

Public health authorities also include individuals and entities acting under a grant of authority from, or under a contract with, a public health agency.

Examples of a public health authority include:

- State and local health departments;
- The federal Food and Drug Administration (FDA);
- The CDC; and
- The Occupational Safety and Health Administration (OSHA).

Generally, covered entities must reasonably limit the PHI disclosed for public health purposes, to the minimum amount necessary to accomplish the public health purpose.

However, covered entities are not required to make a "minimum necessary determination" for public health disclosures that are made either under an individual's authorization, or for disclosures that are required by other law.

For disclosures to a public health authority, covered entities may reasonably rely on a minimum necessary determination made by the public health authority that is requesting the protected health information.

For routine and recurring public health disclosures, covered entities may develop standard protocols, as part of their minimum necessary policies and procedures, that address the types and amount of PHI that may be disclosed for such purposes.

WHEN ELSE DOES THE HIPAA PUBLIC HEALTH EXCEPTION APPLY?

The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities. Covered entities may, therefore, under the Privacy Rule, disclose PHI, without authorization, for the following public health investigations:

- **Child abuse or neglect:** Covered entities may disclose PHI to report known or suspected child abuse or neglect, provided the report is made to a public health or other appropriate government authority authorized to receive such reports under law. Such authorities may include (among other entities) social services departments of local governments and police departments.
- **Quality, safety, or effectiveness of a product or activity regulated by the FDA:** Covered entities may disclose PHI to persons (e.g., individuals, entities, partnerships, and corporations) subject to FDA jurisdiction, if the disclosure is for a public health purpose that is related to the quality, safety, or effectiveness of an FDA-regulated product or activity for which that person has responsibility. Examples of purposes or activities for which such disclosures may be made include (but are not limited to):
  - — Collecting or reporting product defects or problems (including problems regarding use or labeling);
  - — Tracking FDA-regulated products;
  - — Enabling product recalls, repairs, or replacement.
- **Persons at risk of contracting or spreading a disease:** A covered entity may disclose PHI to a person who is at risk of contracting or spreading a disease or condition, if other law authorizes the covered entity to notify such individuals as necessary to carry out public health interventions or investigations.
- **Workplace medical surveillance:** A covered healthcare provider who provides a healthcare service to an individual at the request of the individual's employer, or provides the service in the capacity of a member of the employer's workforce, may disclose the individual's PHI to the employer for the purposes of workplace medical surveillance or *the evaluation of work-related illness and injuries* to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration , or the requirements of state laws having a similar purpose. In such instances, the covered provider must give written notice to the individual that the information will be disclosed to the individual's employer. As an alternative to having to give written notice to the individual, the notice may be posted at the worksite, *if* that is where the service is provided.

PATIENT PRIVACY

Understandably, your staff is concerned when patients report with symptoms of the novel coronavirus COVID-19, which have included mild to severe respiratory illness with fever, cough, and difficulty breathing. Fears about contracting the virus could lead healthcare employees to look at PHI impermissibly and share information of patients presenting with these symptoms.

Although healthcare employees are encouraged to answer patient questions about coronavirus and take precautions when dealing with patients presenting with upper respiratory symptoms, they must remember they may not access or disclose patient records for an unauthorized purpose. Curiosity may tempt employees to look up a patient's medical record to see if the record includes evidence of any discussions a patient may have had with a provider about coronavirus. However, employees should especially resist this temptation with respect to patients who have sought treatment for mild to severe respiratory illness. HIPAA regulations still apply, and under HIPAA, employees may access or disclose patient records only when specifically authorized to do so as part of their job, or when required to do so under law.

Review and/or update privacy procedures in your Policies and Procedures manual to reinforce this HIPAA rule.

TELEHEALTH RULES

During the COVID-19 pandemic, emergency HIPAA waivers made it easier for physicians to provide virtual services. For many, the pandemic and subsequent shutdowns may have resulted in offering telehealth services never before considered. However, these relaxed rules were never meant to be permanent. Eventually, the government will clamp down on telehealth HIPAA compliance with violation penalties as high as $50,000 per occurrence.

Complying with the stricter HIPAA telehealth regulations when the COVID-19 waivers expire is essential to your ability to continue to offer these much sought-after services. Now is the time to review your telehealth procedures to ensure you are complying with the normal HIPAA requirements. Be sure your virtual platform complies with HIPAA rules that were in effect before the relaxed regulations were put into place. Review all rules with staff, who may have become accustomed to the relaxed telehealth rules allowed during the height of the pandemic.

NEW EMPLOYMENT POLICIES

The "new normal" also applies to your employment policies to comply with new state and federal COVID-19 employment rules. You must also ensure compliance with other related government agencies and laws that have been modified due to changing circumstances. These include the Americans with Disabilities Act (ADA), the Equal Employment Opportunity Commission, and the United States Department of Labor, among others.

The new employment laws affect everything, from what you are required to pay when an employee is out sick to the safety of the work environment within your practice. Ignoring these new employment regulations really is not an option— it leaves your practice seriously exposed to legal and governmental audits and penalties.

Several employment policy questions you must consider adding to your Policies and Procedures manual include the following:

- If testing is available, can you legally test employees for COVID-19?
- Are you violating ADA laws if you require pregnant or high-risk staff to stay home?
- Can you require staff to use accumulated paid time off as compensation if you send them home?
- How do you know if you are required to comply with Federal Families First Coronavirus Act?
- If an employee reports that they've tested positive for COVID-19, can you inform other staff?
- What are your obligations to the Emergency Family & Medical Leave Expansion Act (EFMLEA)?
- What obligations do you have related to the Emergency Paid Sick Leave Act (EPSL)?
- Are you required to comply with both state and federal employment regulations?
- How can you reduce your liability if an employee becomes infected with COVID-19 at work?
- What is the best way to document the communication of new employment policies?
- If employees work from home, are you required to reimburse home expenses (e.g., Internet)?
- Do you have an obligation to report employees with symptoms of COVID-19?
- When is it safe to let a COVID-19–positive employee return to work?
- How long must you hold a position open for an employee who can't come to work?
- How high does an employee's temperature need to be for that employee to be sent home?
- What should you do if you tell an employee to go home and they refuse?
- Are there documentation requirements for COVID-19–positive employees?
- Are you required by EFMLEA and EPSL to pay an employee for time they don't actually work?
- If an employee tests positive for COVID-19, are you required to record an OSHA incidence?
- How do you amend your FMLA and leave policies to align with updated COVID-19 regulations?
- How does COVID-19 change your ADA compliance?
- Are there specific PPE items that you are required to provide to staff?

SUMMARY

HIPAA rules and employment regulations, as well as your entire Policies and Procedures Manual, should be reviewed, updated, and reissued to all employees periodically. In the face of a public health emergency such as the coronavirus, it is imperative that all employees be reminded of how important it is to follow the HIPAA privacy rules regarding PHI and that all new rules regarding patient safety and employee matters be recognized.

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. . . And the Enemy Is Us

Randy R. Bauman*

Dr. Smith loved Microsoft Word. This handy software counts not only the number of words in a document but also the number of characters, with and without spaces. This information was critical to Dr. Smith because he was in charge of his four-physician specialty group's income calculation. This calculation determined the income of each of the physicians and was so important to Dr. Smith that he cleared his schedule for two full days each quarter to attend to it.

There's an old adage that when the size of the pie shrinks, table manners change, and this was certainly the case with Dr. Smith's group. Their revenues were down and so were their incomes, even though patients often had to wait several days, or even weeks, for an appointment. The doctors felt their overhead was too high and the way their income formula allocated it wasn't "fair." They hired me and my company to take a look at it and to recommend changes.

As I prepared for my first meeting with Dr. Smith's group, I reviewed the minutes of their board meetings for the past six months. What I found was truly amazing. In one month the minutes described a long discussion about how to allocate transcription costs, which was currently billed by the page. One doctor stated that doing it by the page wasn't "fair" because some pages only contained one or two lines. He suggested alternatively that it would be fairer to allocate transcription costs by line.

This change was subsequently approved, but the next month another physician stated that all lines weren't full and that it would be fairer to allocate these costs by the word. You can't make this stuff up. And yes, the next month they decided to allocate transcription costs by the character (I don't know if they counted spaces or not). As I sat back in my chair and sighed, I remembered the famous quote from the comic strip Pogo, which read, "We have met the enemy and he is us." This, I believed, summed up the situation perfectly.

As I got further involved with the group, it got worse. It turned out that each patient visit generated a separate "cost ticket," which clinical staff dutifully completed and filed, accounting for the individual supply costs incurred during every visit. This included ear swabs, tongue depressors, syringes, and virtually everything else used. This was what Dr. Smith did with the two days he took off every quarter. He spent it meticulously summarizing the cost tickets to determine which supply costs needed to be charged to each physician in the practice.

At this point I began to wonder whether Dr. Smith, who was delightful to work with, had missed his calling as an accountant. But then I realized that even the most detail-oriented accountants understand the concept of materiality and learn the fallacy of "counting paperclips."

Doctors are trained to be critical thinkers, to assess a cadre of symptoms and arrive at a diagnosis and course of treatment, often in a short period of time. These critical thinking skills often result in the innate ability to argue virtually any side of an argument, often simultaneously. These skills were definitely at work with Dr. Smith and his partners as they discussed how to allocate overhead. Everybody had an argument about why it should be done a different way—in a way that would benefit themselves to the detriment of their partners. I quickly came to understand why and how they had come to the absurd cost ticket system.

I would like to tell you that there was a happy ending, and there was, at least for a few years. I convinced Dr. Smith and his group that spending time seeing patients was more important than cost accounting small items, and we came up with a vastly simplified method. Ultimately, however, they sold their practice to a local hospital where their compensation was based on productivity, letting the hospital worry about the overhead.

So when physicians say that they are selling their practice because they are tired of dealing with the "business side," that is often true. But the nature and extent of that business side may be partially their own doing or undoing.

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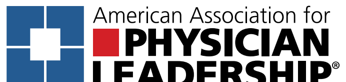

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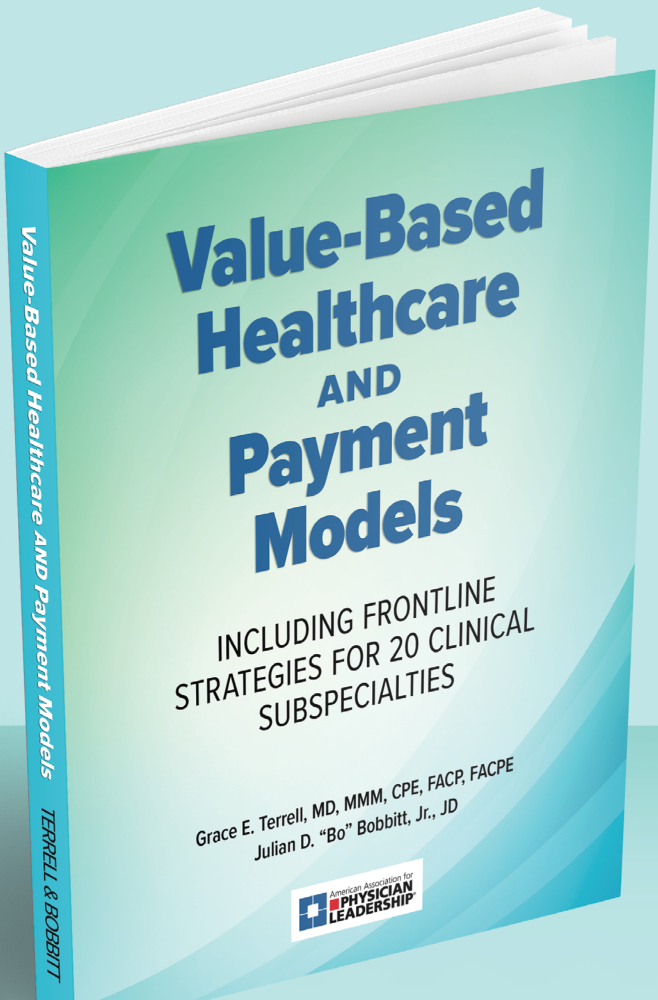

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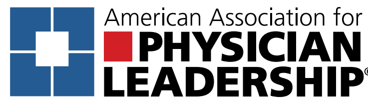

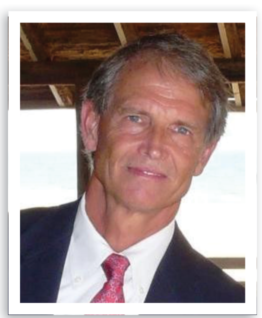

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